Midlands Partnership NHS Foundation Trust

Evidence appendix

Trust Headquarters
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Date of inspection visit:
19 Feb to 10 Apr 2019

Date of publication:
5 July 2019

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 35 locations registered with the CQC (on 20 February 2019).

Registered location	Code	Local authority
Bentilee Neighbourhood Centre (Dental Services)	RREZ5	Stoke-on-Trent
Burton ISHS Hub	RREZ3	Staffordshire
Cannock Dental Access Centre (Dental Services)	RRES1	Staffordshire
Codsall Clinic (Dental Services)	RRES8	Staffordshire
Cross Street Clinic (Dental Services)	RRES5	Staffordshire
George Bryan Centre	RRE58	Staffordshire
HQ Community Services	RRES2	Staffordshire
Hanley Health Centre (Dental Services)	RREZ6	Stoke-on-Trent
Haywood Hospital	RREU8	Stoke-on-Trent
Home First – Cannock	RREU5	Staffordshire
Home First – East Staffs	RREU3	Staffordshire
Home First – Lichfield & Tamworth	RREU4	Staffordshire
Home First – Moorlands	RREU1	Staffordshire
Home First – Newcastle	RRES3	Staffordshire
Home First – South Staffordshire	RRES6	Staffordshire
Home First – Stafford	RREU2	Staffordshire
Home First – Stoke	RREU6	Stoke-on-Trent
Leek Moorlands Hospital	RREU9	Staffordshire
Meir Primary Care Centre (Dental Service)	RREZ7	Stoke-on-Trent
Oak House	RREX8	Shropshire
Poswillo Dental Suite (Dental Service)	RREZ8	Stoke-on-Trent

Registered location	Code	Local authority
Ryecroft Primary Care Centre (Dental Services)	RREZ9	Staffordshire
Sandy Lane Health Centre (Dental Services)	RRES9	Staffordshire
Severn Fields Health Village (Hub)	RREHC	Shropshire
St George's Hospital	RRE11	Staffordshire
St George's Hospital - Forensic	RRE10	Staffordshire
St George's Hospital - Specialist	RRE13	Staffordshire
Stafford Central ISHS Hub	RREZ2	Staffordshire
Stafford Dental Access (Dental Service)	RRES4	Staffordshire
Stoneydelph Health Centre (Dental Service)	RRES7	Staffordshire
Tamworth ISHS Hub	RREZ4	Staffordshire
Telford and Wrekin ISHS (Hub)	RREJW	Telford & Wrekin
The Flanagan Centre	RRE4F	Staffordshire
The Redwoods Centre	RRERS	Shropshire
Tunstall Health Centre (Dental Services)	RREU0	Stoke-on-Trent

The trust had 464 inpatient beds across 30 wards, none of which were children's mental health beds. The trust also had 82 community mental health clinics and 1526 community physical health clinics per week.

Total number of inpatient beds	464
Total number of inpatient wards	30
Total number of day-case beds	12
Total number of children's beds (mental health setting)	0
Total number of children's beds (community setting)	0
Total number of acute outpatient clinics per week	204
Total number of community mental health clinics per week	82
Total number of community physical health clinics per week	1526

The methodology of CQC trust 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 had the appropriate range of skills, knowledge and experience to perform its role. The trust board consisted of the chair, chief executive, six non-executive directors and five executive directors. Two further directors (workforce and social care) also attended board meetings along with the four managing directors of the operational care groups. There was one post being recruited to at the time of inspection following the announcement of the retirement of the Director of Quality and Clinical Performance.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. At care group level the managing directors were supported by professional and service leads with the right skills and experience.

The trust board and senior leadership team displayed integrity on an ongoing basis. External stakeholders told us that the executive members of the board were always open to challenge and demonstrated a firm commitment to quality of care as the organisation's priority.

Fit and Proper Person checks were in place. We reviewed the personnel files of four executive and four non-executive members of the board and found that all the relevant checks had been made. All files demonstrated consistent processes undertaken to evidence 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.

When senior leadership vacancies arose, the executive team reviewed capacity and capability needs. In the most recent recruitment of a non-executive board member, a very clear set of skills and experience was required after a review of the board's capacity.

The trust reviewed leadership capacity and capability on an ongoing basis. All members of the board received an annual appraisal and had personal development plans.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and acted to address them. At each board meeting the chief executive presented a paper that reviewed changes in the local and national health and social care economy. There was also an analysis of the potential opportunities and threats to the trust for the board to discuss and agree a plan to address them. Senior executives were heavily involved in local (sustainability and transformation partnerships) and national programmes. The board had recently met in a special meeting to review and agree the trust making a significant financial contribution to support the ongoing development of local services through the sustainability and transformation partnership.

There was a programme of board visits to services and staff fed back that leaders were approachable. Throughout our core service visits, we found that staff were very positive about the visibility of the executive team. The chief executive had been very visible throughout the process of merging with the community health services. Executive directors, non-executive directors and governors were all involved in the programme of visits.

Leadership development opportunities were available, including opportunities for staff below team manager level. The trust had put an emphasis on leaders developing skills and understanding the improvement methodologies that were widely used within the trust. Leadership development opportunities were available for staff at different levels of the organisation linked to their appraisals and personal development plans. The trust with other local partners had invested in the development of a black and minority ethnic (BME) leadership programme.

Succession planning was in place throughout the trust. The trust had a programme of development and talent management in place.

The executive board had one (7.7%) black and minority ethnic (BME) member and three (23.0%) women. The non-executive board had one (7.7%) BME member, and four (30.8%) women.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities.

The trust had three core values (people, empowerment and partnership) related to one vision '; 'together we are making life better for our communities'. Their objectives were: to provide high quality health and social care services; to use our resources to maintain a sustainable, effective organisational offer; building partnerships to benefit the health and wellbeing of our local population; to expand our service portfolio to enrich services; to make our Trust a fantastic place to work. The trust had a five-year strategy that aligned its aspirations through these five aims, three values and one vision. This strategy has been aligned to the NHS Mandate and other external drivers.

In partnership with service users, carers and staff they had also identified a set of behaviours which supported the delivery of their objectives.

Throughout our focus groups and during core service visits we found staff were generally aware of and shared the trust's vision and values. Staff within some of the community health services that

had recently joined the trust were aware of the values and they were embedded within staff appraisals. This ensured staff knew how they applied to their work.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. The trust had a clear strategy for attaining its values through a combination of a programme of continuous improvement for existing services and integrating services to provide holistic care.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. Service users were regularly involved in discussions about future development of services through the Involvement for Impact scheme.

Local trusts and people who use services had been involved in developing the strategy.

Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. Within the mental health core services, the staff had a very good understanding of the trust's vision and value. In the more newly acquired community health services, the trust was holding engagement events to actively promote the vision and values to new staff.

The trust embedded its vision, values and strategy in corporate information received by staff. We saw that in the documents that had supported the merger of services the goals of developing integrated care services the trust's values had been highlighted as the guiding principles for the future trust. Historically, South Staffordshire and Shropshire Healthcare NHS Foundation Trust produced an annual quality account that outlined the years achievements to staff in terms of advancing its vision and values. The core aims, and values were also incorporated into corporate signing and information throughout the trust.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans.

The trust had planned services to consider the needs of the local population. The four largest ethnic minorities within the trust's catchment population are: 'Asian/Asian British' (12.3%), 'White Other' (8.0%), 'Mix Heritage' (4.3%) and 'Black/Black British' (2.7%). The trust's community engagement strategy recognised all local minority groups and challenges of engaging some of the seasonal Eastern European agricultural workers, prevalent in some of the more rural areas of the trust.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. Within the new care group structure there could be a greater focus on the progress of local plans that were then monitored by the full board in the care group reports.

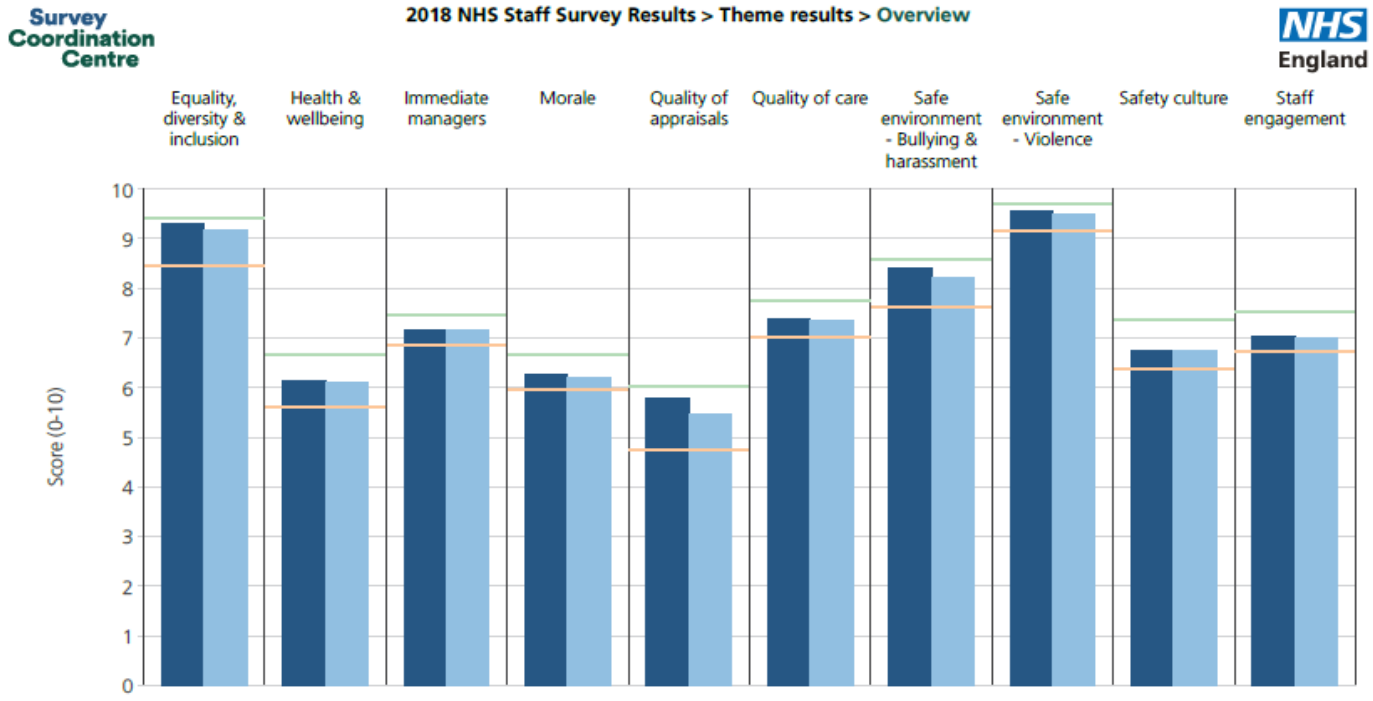
The trust had developed a physical healthcare strategy to meet the needs of patients across mental health and learning disabilities inpatient and community settings. The trust had provided staff with training around the management of physical health care problems and there were physical health care leads attached to inpatient areas. Following the merger, the presence of community healthcare services as part of the trust had provided opportunity for better joint working on the physical healthcare needs of mental health patients, and access to physical health specialists. We heard very positive reports of these developments in focus groups covering the South Staffordshire area where these initiatives were most developed.

There was a robust and realistic strategy for achieving their priorities and developing good quality, sustainable care across all sectors. The trust had a clear strategy to create integrated care services based on the neighbourhoods set out in the sustainability and transformation plans. This included partnership working with local acute trusts in the development of specialist teams focusing on the complex need of older adults.

Culture

Staff felt respected, supported and valued. Staff reported this through generally positive and above average responses to questions around leadership, morale and level of engagement in the annual staff survey.

The following illustration shows how this trust compares with other similar trusts on ten key themes from the 2018 NHS Staff Survey. Possible scores range from zero to 10 – a higher score indicates a better result. The trust scored higher than the national average in five areas. These results reflect the opinion of staff in November 2018 within South Staffordshire and Shropshire Healthcare NHS Foundation Trust before the creation of Midlands Partnership NHS Foundation Trust.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.3	6.1	7.2	6.3	5.8	7.4	8.4	9.6	6.8	7.0
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7
Responses	4,713	4,757	4,775	4,695	4,214	4,132	4,673	4,661	4,733	4,832

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The trust's strategy, vision and values underpinned a culture which was patient centred. Staff felt positive and proud about working for the trust and their team. They also reported above the national average, feeling safe at work in an environment free of the threat of bullying, harassment and physical violence.

The trust recognised staff success by staff awards and through feedback. Throughout the year, the trust held several events to celebrate the achievements of staff within the trust. Regular staff newsletters reported on awards and other external recognition received by staff within the trust. The executive team used social media to highlight areas of outstanding practice by individuals and teams.

The trust worked appropriately with trade unions. Managers addressed poor staff performance where needed. We examined a sample of human resources files that detailed performance issues with individual staff members and found the processes to be robust. Any concerns were managed in a timely manner.

The trust had appointed two Freedom to Speak Up Guardians and provided them with enough resources and support to help staff to raise concerns. The two Freedom to Speak Up Guardians (one from each of the legacy organisations) had a clear strategy for promoting a positive culture of speaking up within the trust. The Guardians produced regular reports on activity to the board and held more frequent meetings with their executive and non-executive leads to review any concerns.

There had been joint working and reporting from the two Guardians before the merger and this had cemented their central role in the effective engagement with staff as a trust priority. The board had completed a self-assessment exercise to benchmark their practice against national guidance. They were compliant overall with a few areas for improvement identified which had been taken forward into an action plan. There were some areas of the trust where staff did not have a good understanding of the role and the Guardians aimed to develop a network of champions to embed knowledge of the role in local services.

The handling of concerns raised by staff was always in line with best practice. We saw evidence that managers engaged fully with concerns raised by staff in most services we inspected.

Staff felt able to raise concerns without fear of retribution. In discussion with staff who had transferred with the community health services, we heard very positively of their feeling of having moved to a trust with an open culture, where their concerns would be heard without prejudice.

Staff knew how to use the whistleblowing process and about the role of the Freedom to Speak Up Guardian. In most of our core service inspections, staff told us they understood the whistleblowing processes and how to access the Freedom to Speak up Guardian if required.

The trust applied Duty of Candour appropriately. The board received regular reports on the use of the duty of candour and any developing trends.

The trust took appropriate learning and action because of concerns raised. The quality team provided a summary of lessons learnt from complaints and how they had been implemented as a routine part of their complaint's summary that was presented to the board.

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

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had also appointed a full-time public health consultant who had contributed towards the development of a health and well-being strategy for staff within the trust. Staff in some services were now engaged in regular well-being sessions. Staff had been involved in reflective practice, yoga, meditation and mindfulness sessions as part of this programme.

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. The workforce development team had been working since the merger to bring the Workforce Race Equality Standard (WRES) improvement plans from the two legacy organisations together into a common plan.

They provided the CQC with an update on progress to March 2019 on the WRES Priority Improvement Plan:

- The Trust had supported 30 Black and minority ethnic staff to access and complete the Stepping Up Leadership Programme funded by the local sustainability and transformation partnerships.
- The trust was selected for the WRES Expert Programme in January 2019 and this provides support and expertise from the national team as well as developing the expertise within trust.
- Listening into Action events for equality and inclusion had enabled feedback from black and minority ethnic staff within the trust. Managers would use this data to inform the WRES improvement Plan for 2019. Staff had requested further events across more of the trust's sites and services to include as many staff as possible.
- Work was underway at care group level on developing the equality and inclusion strategy at a local service level.
- The trust had recently approved the establishment of an equality and inclusion assurance group to provide assurance that the equality and inclusion agenda was a priority across all care groups and trust services. The group would discuss WRES findings and updates will be provided prior to presentation at the workforce development committee and trust board.

Staff networks were in place promoting the diversity of staff. The WRES strategy outlined above sought to strengthen and develop these groups.

Teams had positive relationships, worked well together and addressed any conflict appropriately.

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.

From May to September 2018, the trust scored lower than the England average for the percentage of mental health patients who would recommend the trust as a place to receive care in five of the six months. The trust scored higher than the England average in terms of the percentage of patients who would not recommend the trust for four of those 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**
Sep 2018	10470	98	88%	2%	90%	4%
Aug 2018	10619	71	86%	6%	90%	3%
July 2018	11049	94	74%	10%	89%	4%
June 2018	10710	83	83%	7%	89%	4%
May 2018	8889	43	84%	5%	89%	4%
Apr 2018	10732	50	92%	4%	89%	4%

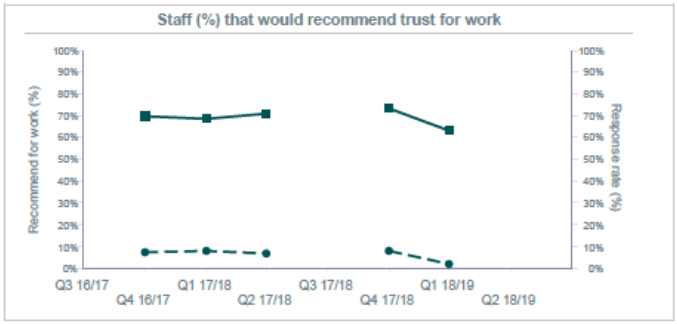
From June to September 2018 (accurate data for April and May was not available), the trust scored higher than the England average for the percentage of community patients who would recommend the trust as a place to receive care in all four reported months. The trust scored the same as the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in all four reported months.

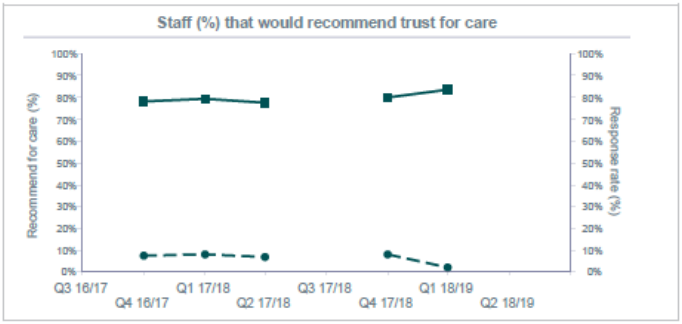
	Trust wide responses				England averages	
	Total eligible	**Total responses**	**% that would recommend**	**% that would not recommend**	**England average recommend**	**England average not recommend**
Sep 2018	70548	2158	98%	1%	96%	1%
Aug 2018	72547	2580	98%	1%	97%	1%
July 2018	73907	2789	97%	1%	96%	1%
June 2018	73291	2644	97%	1%	96%	1%
May 2018	N/A	N/A	N/A	N/A	96%	1%
Apr 2018	N/A	N/A	N/A	N/A	96%	1%

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

The percentage of staff that would recommend the trust as a place to work in Q1 2018/2019 stayed about the same when compared to the same time last year.

The percentage of staff that would recommend this trust as a place to receive care in Q1 2018/2019 stayed about the same when compared to the same time last year.





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

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

As of 30 September 2018, the trust had reported a vacancy rate of 9% for all staff; with a vacancy rate of 7% for registered nurses and 10% for healthcare assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Core service	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
MH - Wards for people with learning disabilities or autism	3.7	9.3	39%	3.5	12.4	29%	7.4	22.7	33%
CHS - Urgent Care	5.8	25.4	23%	3.0	15.7	19%	8.8	41.1	21%
CHS - Community Inpatients	24.7	111.3	22%	16.0	132.8	12%	46.8	256.3	18%
Other - ASC service	0.0	1.0	0%	1.0	4.0	25%	69.3	391.5	18%
Other - PMS service	8.4	71.3	12%	5.9	53.6	11%	56.4	395.4	14%
MH - Community mental health services for people with a learning disability or autism	1.1	43.2	3%	0.5	19.0	3%	12.0	103.2	12%
CHS - End of Life Care	1.0	8.3	12%	0.0	0.6	1%	1.0	8.9	11%
CHS - Sexual Health	4.7	69.5	7%	16.4	115.7	14%	25.6	225.9	11%
MH - Secure wards/Forensic inpatient	12.1	105.7	11%	14.9	103.9	14%	30.8	269.4	11%
CHS - Adults Community	61.8	614.0	10%	30.9	288.3	11%	148.2	1531.8	10%
MH - Acute wards for adults of working age and psychiatric intensive care units	13.0	100.4	13%	7.1	96.7	7%	23.4	231.3	10%
MH - Substance misuse	4.5	26.9	17%	0.2	17.0	1%	15.2	154.5	10%
CHS - Community Dental	-	-	-	-0.2	3.2	-7%	6.6	78.9	8%
MH - Specialist community mental health services for children and young people	5.9	51.9	11%	-1.6	38.7	-4%	12.9	160.9	8%
MH - Other Specialist Services	4.4	45.3	10%	4.2	30.7	14%	9.0	113.1	8%
CHS - Children, Young People and Families	-19.9	275.8	-7%	28.1	197.5	14%	42.8	647.9	7%
MH - Wards for older people with mental health problems	3.1	68.2	5%	4.4	77.2	6%	7.7	167.2	5%

	Registered nurses			Health care assistants			Overall staff figures		
Core service	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
MH - Community-based mental health services for older people	3.4	73.2	5%	4.6	54.9	8%	6.7	158.0	4%
MH - Community-based mental health services for adults of working age	3.5	198.1	2%	5.0	116.9	4%	4.3	557.8	1%
MH - Mental health crisis services and health-based places of safety	-0.8	67.9	-1%	1.9	38.1	5%	0.1	119.0	0%
Trust total	**140.5**	**1969.7**	**7%**	**146.8**	**1424.0**	**10%**	**536.1**	**5645.8**	**9%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 30 September 2018, of the 3,781,640 total working hours available across the trust, 3% 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 1% of available hours for qualified nurses and 1% of available hours were unable to be filled by either bank or agency staff.

Core service	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
MH - Wards for people with learning disabilities or autism	15650	2594	17%	0	0%	146	1%
MH - Secure wards/Forensic inpatient	206053	20981	10%	6170	3%	3581	2%
MH - Acute wards for adults of working age and psychiatric intensive care units	198809	17575	9%	8286	4%	4751	2%
MH - Other Specialist Services	88363	4478	5%	1200	1%	782	1%
MH - Wards for older people with mental health problems	133975	6891	5%	3953	3%	4538	3%
CHS - Community Inpatients	170009	7433	4%	12100	7%	666	<1%
MH - Mental health crisis services and health-based places of safety	136881	3857	3%	0	0%	224	<1%
MH - Specialist community mental health services for children and young people	107196	2304	2%	1618	2%	279	<1%
CHS - Sexual Health	136914	2531	2%	0	0%	82	<1%
CHS - Children, Young People and Families	543563	5786	1%	0	0%	595	<1%
MH - Community-based mental health services for adults of working age	387138	3558	1%	3018	1%	196	<1%

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Substance misuse	56872	673	1%	0	0%	30	<1%
CHS - Adults Community	1187167	15538	1%	2517	0%	9064	<1%
Other - PMS service	132689	1610	1%	84	0%	23	<1%
CHS - Community Dental	0	0	1%	0	0%	0	0%
CHS - Urgent Care	50347	299	1%	8	0%	60	<1%
MH - Community-based mental health services for older people	128094	69	0%	0	0%	0	0%
MH - Community mental health services for people with a learning disability or autism	83944	289	0%	0	0%	15	<1%
Other - ASC service	1631	0	0%	0	0%	0	0%
CHS - End of Life Care	16345	0	0%	0	0%	0	0%
Trust Total	**3781640**	**96462**	**3%**	**38953**	**1%**	**25030**	**1%**

Between 1 October 2017 and 30 September 2018, of the 1,847,533 total working hours available, 12% were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants.

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

In the same period, agency staff covered 4% of available hours and 2% of available hours were unable to be filled by either bank or agency staff.

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Other - PMS service	1794	2440	136%	0	0%	179	10%
MH - Acute wards for adults of working age and psychiatric intensive care units	180057	73776	41%	26565	15%	18008	10%
MH - Other Specialist Services	45806	15065	33%	1473	3%	1919	4%
MH - Secure wards/Forensic inpatient	181630	57936	32%	11941	7%	6011	3%
MH - Wards for older people with mental health problems	138062	26092	19%	7251	5%	8739	6%
MH - Wards for people with learning disabilities or autism	19937	3189	16%	0	0%	38	<1%
CHS - Community Inpatients	206875	20602	10%	30581	15%	2484	1%
MH - Specialist community mental health services for children and young people	7067	483	7%	0	0%	8	<1%
CHS - Children, Young People and Families	267311	5406	2%	0	0%	41	<1%
CHS - Adults Community	358513	3324	1%	611	0%	307	<1%
MH - Community-based mental health services for older people	79399	409	1%	0	0%	6	<1%
CHS - Sexual Health	82925	593	1%	0	0%	40	<1%

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	69433	1032	1%	0	0%	110	<1%
CHS - Urgent Care	29685	19	0%	0	0%	0	0%
MH - Community mental health services for people with a learning disability or autism	14290	0	0%	0	0%	0	0%
Other - ASC service	52711	0	0%	0	0%	0	0%
MH - Community-based mental health services for adults of working age	104792	63	0%	0	0%	29	<1%
CHS - Community Dental	7246	0	0%	0	0%	0	0%
MH - Substance misuse	0	10204	-	0	-	264	-
CHS - End of Life Care	0	0	-	0	-	0	-
Trust Total	1847533	220632	12%	78422	4%	38181	2%

This trust had 679.3 (14%) staff leavers between 1 October 2017 and 30 September 2018.

Core service	Substantive staff (latest month)	Substantive staff Leavers (over the past 12 months)	Average % staff leavers (over the past 12 months)
CHS - End of Life Care	7.9	3.6	41%
Other - ASC service	322.2	74.1	25%
MH - Substance misuse	139.2	28.8	20%
MH - Specialist community mental health services for children and young people	147.9	26.1	18%
MH - Community mental health services for people with a learning disability or autism	91.2	14.6	16%
Other - PMS service	339.2	47.6	15%
CHS - Children, Young People and Families	605.1	93.0	15%
MH - Community-based mental health services for adults of working age	553.5	78.1	14%
CHS - Adults Community	1393.6	176.9	13%
CHS - Community Inpatients	209.6	24.3	12%
MH - Acute wards for adults of working age and psychiatric intensive care units	207.7	25.2	12%
MH - Community-based mental health services for older people	151.3	14.4	11%
CHS - Urgent Care	32.3	3.4	11%
MH - Secure wards/Forensic inpatient	238.7	24.5	10%
CHS - Sexual Health	200.2	20.7	10%
MH - Mental health crisis services and health-based places of safety	118.9	9.0	8%
MH - Other Specialist Services	104.1	5.6	6%
CHS - Community Dental	72.3	2.8	4%
MH - Wards for older people with mental health problems	159.4	6.6	4%
MH - Wards for people with learning disabilities or autism	15.3	0.0	0%
Trust Total	**5109.7**	**679.3**	**14%**

Senior managers recognised the challenging healthcare economy and its impact on workforce recruitment and maintaining safe and quality care. 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 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 within 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 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 90% for completion of mandatory training and 95% for Information Governance training as set out in the IG Toolkit for Trusts 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.

Sickness and absence figures were not outliers. The sickness rate for this provider was 5.2% between 1 October 2017 and 30 September 2018. The most recent month's data for September 2018 showed a sickness rate of 4.7%.

Core service	Total % staff sickness (at September 2018)	Ave. % permanent staff sickness (1 Oct 2017 – 30 Sep 2018)
Other - ASC service	9.8%	9.3%

Core service	Total % staff sickness (at September 2018)	Ave. % permanent staff sickness (1 Oct 2017 – 30 Sep 2018)
MH - Wards for people with learning disabilities or autism	4.1%	8.5%
MH - Wards for older people with mental health problems	6.2%	7.4%
CHS - Sexual Health	5.3%	6.1%
MH - Acute wards for adults of working age and psychiatric intensive care units	4.9%	6.1%
CHS - Community Inpatients	6.1%	5.7%
Other - PMS service	4.9%	5.3%
CHS - Community Dental	5.5%	5.3%
MH - Community-based mental health services for adults of working age	4.7%	5.0%
CHS - Adults Community	3.7%	4.9%
MH - Mental health crisis services and health-based places of safety	4.6%	4.9%
MH - Community-based mental health services for older people	5.0%	4.7%
MH - Specialist community mental health services for children and young people	3.0%	4.5%
MH - Secure wards/Forensic inpatient	3.4%	4.5%
CHS - Children, Young People and Families	4.8%	4.4%
MH - Community mental health services for people with a learning disability or autism	4.1%	4.1%
MH - Substance misuse	4.9%	4.0%
MH - Other Specialist Services	4.0%	4.0%
CHS - Urgent Care	0.4%	0.7%
CHS - End of Life Care	0.0%	0.6%
Trust Total	**4.7%**	**5.2%**

The compliance for mandatory and statutory training courses at 30 November 2018 was 86%. Of the 22 training courses listed 12 failed to achieve the trust target and of those, three failed to score above 75%.

The trust set a target of 90% for completion of mandatory and statutory training. The trust reports training on a month by month rolling basis.

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
Corporate Induction	3336	3198	96%	✓
Promoting Safer and Therapeutic Services	1812	1719	95%	✓
Manual Handling - Object	680	641	94%	✓
Mental Capacity Act Level 2	4775	4480	94%	✓
Local Induction	5607	5220	93%	✓
Conflict Resolution	3456	3172	92%	✓
Equality and Diversity	5607	5107	91%	✓
Safeguarding Adults (Level 1)	5573	5080	91%	✓
Safeguarding Children (Level 2)	5574	5041	90%	✓
Health and Safety (Slips, Trips and Falls)	3336	3009	90%	✓
Prevent Awareness	5607	5016	89%	✘
Safeguarding Children (Level 3)	1755	1552	88%	✘
DMI - Foundation Violence & Aggression	575	507	88%	✘
Adult Basic Life Support	4745	3951	83%	✘
Fire Safety - 1 Year	5607	4634	83%	✘
Infection Prevention (Level 1)	4780	3891	81%	✘
Fire Safety Instruction & Evacuation - Level 3	804	648	81%	✘
Information Governance	5607	4502	80%	✘
Medicine management training	834	667	80%	✘
Clinical Risk Assessment	1588	1181	74%	✘
Mental Health Act	1077	757	70%	✘
Manual Handling - People	4851	2752	57%	✘
Total	**77586**	**66725**	**86%**	

The lowest figure for mandatory training was in the teaching of manual handling patients' skills to staff. We were told that this had been due to the unforeseen absence of the trainer and a suitable replacement had been sourced. The Trust had reviewed its mandatory training requirements following the development of Midlands Partnership Foundation Trust and added manual handling as an additional requirement for some services. This was reflected in lower levels of compliance as those staff for whom it was new went through face to face training

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff was 88%. This year so far, the overall appraisal rate was 81% (as at 30 November 2018). From last year's compliance, 10 of the core services achieved the trust's appraisal target and the service with the lowest compliance was 'Mental health crisis services and health-based places of safety' with 65%.

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 30 November 2018)	% appraisals (previous year 1 Apr 2017 – 31 Mar 2018)
CHS - End of Life Care	7	5	71%	100%
CHS - Urgent Care	41	31	76%	98%
MH - Substance misuse	64	61	95%	96%
Other - ASC service	260	204	78%	94%
CHS - Community Dental	89	70	79%	93%
CHS - Sexual Health	188	157	84%	92%

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 30 November 2018)	% appraisals (previous year 1 Apr 2017 – 31 Mar 2018)
CHS - Children, Young People and Families	595	449	75%	92%
MH - Community-based mental health services for older people	135	125	93%	92%
CHS - Adults Community	1331	1024	77%	91%
MH - Secure wards/Forensic inpatient	202	176	87%	91%
MH - Wards for people with learning disabilities or autism	13	10	77%	88%
CHS - Community Inpatients	192	134	70%	87%
MH - Acute wards for adults of working age and psychiatric intensive care units	161	154	96%	87%
MH - Wards for older people with mental health problems	143	139	97%	86%
MH - Community mental health services for people with a learning disability or autism	86	64	74%	84%
MH - Community-based mental health services for adults of working age	475	404	85%	81%
MH - Other Specialist Services	94	76	81%	77%
Other - PMS service	179	142	79%	71%
MH - Specialist community mental health services for children and young people	129	88	68%	68%
MH - Mental health crisis services and health-based places of safety	106	102	96%	65%
Total	**4490**	**3615**	**81%**	**88%**

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff was 80%. This year so far, the overall appraisal rate was 56% (as at 30 November 2018). As of the end of last year, six core services achieved the trust's appraisal target and the service with the lowest compliance was 'CHS Sexual Health' with 63%.

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 30 November 2018)	% appraisals (previous year 1 Apr 2017 – 31 Mar 2018)
MH - Acute wards for adults of working age and psychiatric intensive care units	8	6	75%	100%
MH - Community mental health services for people with a learning disability or autism	3	3	100%	100%
MH - Mental health crisis services and health-based places of safety	4	2	50%	100%
CHS - Children, Young People and Families	9	4	44%	100%
MH - Other Specialist Services	3	3	100%	100%
Other - PMS service	0	0	-	100%
MH - Secure wards/Forensic inpatient	6	4	67%	88%
MH - Community-based mental health services for adults of working age	24	19	79%	84%

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 30 November 2018)	% appraisals (previous year 1 Apr 2017 – 31 Mar 2018)
MH - Wards for older people with mental health problems	4	4	100%	80%
CHS - Adults Community	17	2	12%	72%
MH - Specialist community mental health services for children and young people	7	5	71%	71%
MH - Community-based mental health services for older people	13	12	92%	67%
MH - Substance misuse	4	2	50%	67%
CHS - Sexual Health	35	11	31%	63%
Total	**137**	**77**	**56%**	**80%**

Whilst there was centralised monitoring of appraisal and training, the trust relied on local systems to monitor the delivery of supervision compliance. The trust's expectation was that each team manager held a record of access to supervision and was responsible for overseeing compliance with the supervision policy. We saw this was happening in some clinical areas. For example, on Norbury Ward there was a local spreadsheet documenting supervision. In the calendar year 2018 the average supervision rate was 51% per month. However, on this and other wards there was no written record of the supervision to guide future meetings and record progress over time. This fell short of the standards for completion and recording of supervision set out in the legacy supervision policies of the old and the new unified supervision policy ratified in April 2019.

There were similar findings in two other mental health core services; community mental health services for children and young people and at Oak House the learning disability inpatient service. Within the community health services, staff within the urgent care service reported receiving no formal supervision.

In other core services, supervision was more robustly delivered, and staff fed back that they felt it useful. In the community health service for children, young people and families, staff accessed regular specialist supervision around safeguarding.

In our 2016 report on South Staffordshire and Shropshire Healthcare NHS Foundation Trust, we had told the trust that they should monitor and evaluate staff supervision levels centrally and ensure staff receive regular supervision in line with local policy and professional guidelines. The variability in our findings across core services at this inspection reemphasised the need for the trust to have a centralised mechanism to record and monitor supervision across its clinical workforce, to effectively address the shortfalls, the inspections have highlighted.

The trust policy recognises that supervision is widely seen as important to the well-being and the continuous learning and development of staff. It's a forum to support staff, ensure lessons were learnt and embedded in practice. Its effective monitoring centrally would help the trust in monitoring staff health and well-being. The current system does not allow senior managers to regularly review supervision compliance as set out in the trust policy with any assurance.

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. Leaders regularly reviewed these structures.

Each board meeting took assurance reports from the key committees and care groups. Each of the four care groups had regular monthly management meetings to monitor performance and

review issues within the locality/service. The four managing directors also met monthly with the chief executive to review performance.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. The minutes of the meetings were written in an accessible style. Board papers were available to the public in advance on the intranet and were clearly organised with embedded hyperlinks to aid navigation to internal and external sources.

Non-executive and executive directors were clear about their areas of responsibility. Each board member we interviewed had a detailed understanding of their own and other portfolios. Roles had changed following the merger and the new roles introduced of care group managing directors, were well understood.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The director of quality was the executive lead for the Mental Health Act. The mental health act legislation committee met quarterly, looked at incidents and complaints and provided scrutiny of the implementation of the Act. Learning was shared across the trust about complaints and issues related to the Mental Health Act. They reviewed reports from the regular Mental Health Act reviewer visits to mental health wards and the resultant action plans for themes and lessons for the organisation.

A CQC Mental Health Act reviewer had attended one of these meetings as part of our ongoing engagement with the trust. The trust had been responsive to urgent issues raised during any reviewer visits and they reviewed ward based action plans at the regular engagement meetings with the local inspection team.

The trust had systems in place for the receipt and scrutiny of documents. Mental Health Act administrators provided oversight of this process and were available to advise staff when required. There was good support from the Mental Health Act manager to hospital managers across the trust.

Staff training numbers in the Mental Health Act supplied by the trust prior to the inspection were at 70%, however we found on inspection that enough staff in the mental health core services had undertaken training in the Mental Health Act. Most staff were knowledgeable about how to implement the Mental Health Act and the Code of Practice.

There were good working relationships with the police and ambulance services related to section 136 of the Mental Health Act. Section 136 is an emergency power allowing the police to arrest and take a person to a place of safety from a public place, if a police officer considers that the person was suffering from a mental illness and in need of immediate care. The trust met regularly to discuss their duties with the local acute trusts, police and ambulance service. The trusts capacity to accommodate people detained under Section 136 had increased since our last inspection and four people could be detained safely on trust premises. One room had been designated as accessible to children and young people.

The trust had a robust process in place for the recruitment of the Hospital Managers and a recruitment policy to try and reflect the demographics of the local community in the make-up of the panel. The Hospital Managers, who have the power to discharge a person from a Mental Health Act detention, were supported through initial training and regular updates by the trust's legal partner on developments in case law. A non-executive director had oversight of the appointment of the Hospital managers and supported their work within the trust. They had also raised a challenge around recognition of equality and diversity issues in the monitoring and reporting on the use of the Mental Health Act within the trust.

A clear framework set out the structure of ward/service teams, care group and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints, and to act as needed.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

The trust was working with third party providers effectively to promote good patient care. This was evident in many of the services created in partnership with other providers from the third and private sectors in the Inclusion services. The trust had partnered with other providers of online support in creating the 0-25 services for children and young people with mental health problems in Shropshire.

The trust provided a mental health liaison service and was a member of the Psychiatric Liaison Accreditation Network (PLAN). Associated policies and procedures reflected PLAN quality standards. The liaison team serving the Princess Royal in Telford and Royal Shrewsbury Hospital were in the review stage of the accreditation process.

The governance framework addressed the need to meet people's physical health care needs. The standard operating policy on physical health care monitoring was in place and staff trained in identification and actions to support a deteriorating patient. Governance was focused on monitoring compliance levels with mandatory training in this area and case review of any incidents at service level.

On 15 January 2019, the trust was categorised as being 'offered 'targeted support' by the NHS Improvement Single Oversight Framework. In the previous year the trust had received support from NHS Improvement to address some of the problems with the Shropshire, Telford and Wrekin Child and Adolescent Mental Health teams. Their review had led to the action plan, supported by the local commissioners, to improve clinical safety and quality of recording and reporting performance and risk within the service.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months. They did not give any data on current performance as the standard for completing complaints had been different in the two legacy organisations. However, we found that in South Staffordshire and Shropshire Healthcare NHS Foundation trust in a report to their board in October 2018, the trust had received 97 complaints in 2017-18 which is a decrease of 12% from 109 in 2016-17. All 97 complaints received were acknowledged within the required statutory timescale (three working days). Mental health services in Staffordshire had received the highest number of complaints and Patient Advice and Liaison Services (PALS) concerns during 2017/18, but also had the highest number of compliments and the highest amount of contacts. The trust had demonstrated learning and changes to processes because of these complaints. Most complaints (68%) had not been met within the target of 25 days for completing complaints. The trust had negotiated extensions with the complainant in most cases as the cases required additional time to investigate thoroughly. All but five of the complaints resolved were completed within these agreed timescales, extended with the permission of the complainant.

However, we found that complaints within the community health services coming into the trust in June 2018 had much slower responses, despite a longer period (35 days) set out in their legacy complaints policy. The two older policies were to be unified in a new policy at the April 2019 board meeting of the trust. In response to concerns around timeliness and completeness, the investigations team was to investigate complaints in their entirety rather than the existing process whereby senior operational managers complete them within the services themselves.

	In Days	**Current Performance**
What is your internal target for responding to* complaints?	3	98%
What is your target for completing a complaint?	35 (SSOTP) 25 (SSSFT)	-
If you have a slightly longer target for complex complaints, please indicate what that is here	Not provided	Not provided

* 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

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	1522	1 October 2017 to 30 September 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	0	1 October 2017 to 30 September 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

This trust received 10971 compliments during the last 12 months from 1 October 2017 and 30 September 2018. 'CHS Adult Community' services had the highest number of compliments with 7824 (71%) followed by 'CHS Children Young People and Families' with 1300 (12%). Other core services accounted for 3% or less of all compliments received.

Midlands Partnership NHS Foundation Trust submitted details of seven external reviews commenced or published in the last 12 months (1 October 2017 to 30 September 2018. Details can be found in the table below.

External review	Key Outcomes
Reg 28 – Issued 10 January 2018	New operational supervision template introduced Dementia pathway ratified Development of a community falls protocol Development of protocol for use of hospital passport
Reg 28 – Issued 13 November 2017	Single point of access to service implemented, Introduction of a slot per week for urgent assessment in each consultant job plan Escalation processes agreed within each clinical pathway Implementation of electronic patient records Bespoke training on assessment documentation delivered Recruitment to vacant posts Implementation of a joint crisis pathway between adult and CAMHS
Reg 28 – Issues 3 May 2018	Improvements in handover of care and Track & Triage Community Hospital Flow Streamlining and review of patient profile
NHSI 0-25 Service Shropshire - Deep Dive (April 2018) followed by a 2-day service review - June 2018	Results fed back to Executive Directors from the Trust and CCGs July 2018, joint high-level action plan between the Trust and local CCGS developed

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.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The strategic risk register (Board Assurance Framework) had recently been the subject of an external audit to provide the board with assurance about its integrity. This followed a review of risk recording after the merger of the trust in June 2018. Risks from both former legacy systems had been amalgamated into one risk register (MPFT Safeguard system). The quality of reporting was under regular review and the new care group structure allowed for further reviews of performance outside of the board and its sub committees.

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

Staff had access to the risk register either at a team, group or trust level and were able to effectively escalate concerns as needed. The trust operated a stratified risk register in which risks

were graded regarding impact and likelihood and managed at the appropriate level. Within the core services we inspected, we found evidence of local risk registers that were up to date and found staff concerns matched those on the risk register. The exception was the urgent care service where risks around safety and staffing were not recorded at a local level and had not been escalated at the local governance meeting that the local managers attended.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. In most areas we found local staff concerns to be mirrored by the risks held locally and at service level. It was only in the urgent care services where we found no evidence for this.

The trust board had sight of the most significant risks and mitigating actions were clear. Following feedback as part of the external review, the trust had started recording actual evidence in place against each risk rather than an assurance. This was to ensure the board can see the evidence to support the controls in place to manage the risks effectively.

We considered specific risk around medicines and met with the director of pharmacy who had been in post for seven days and the previous director who had taken on another role within the trust. We discussed themes raised through the inspection of the core services and the strategy and risks for the pharmacy team. The department had identified previous risks and ensured that a trust wide process was implemented to mitigate risks within the pharmacy team and the support offered to prescribers. This included engagement with external stakeholders. The medicines optimisation strategy had been cascaded to medicines optimisation team members as part of an away afternoon. The medicines optimisation team had led on engagement with primary care through the local area medicines optimisation committee meetings.

There were plans in place for emergencies and other unexpected or expected events. These plans had been put into action following a fire at one of the inpatient units in February 2019. We talked with staff and managers involved in the initial response and evacuation of the unit. Local staff safely evacuated all patients from the unit, the on-call managers found safe accommodation overnight, and the staff on site offered support. Within 48 hours the trust had been able to open a replacement facility and the ward was reopened at a different site. The fire and police services who attended had positively commented on responsiveness of staff and senior managers.

We met with the trust fire officer and head of estates to discuss the response and lessons learnt. There had been some immediate action taken to reduce any future risks and lessons learnt during their investigation into the integrity of fire compartments had been shared with other NHS organisations.

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.

	Historical data		**Projections**	
Financial Metrics	Previous financial year (2 years ago) (1 Apr 2016 – 31 Mar 2017)	Last financial year (1 Mar 2017 – 31 Apr 2018)	This financial year (1 Apr 2018 – 31 Mar 2019)	Next financial year (1 Apr 2019 – 31 Mar 2020)
Actual income	£194,134	£206,719	£377,858	£378,236
Actual surplus (deficit)	£2,677	£8,512	£4,548	£4,548
Actual costs/expenditure - full	£191,457	£198,207	£373,310	£373,688
Planned budget or (deficit)	£3,130	£3,517	£4,548	£4,548

NHS Improvement have oversight of the financial arrangements at the trust and provided us with the following information and assurances:

The finance team structure was reviewed as part of the merger process and has now settled following a period of reorganisation. The Director of Finance had many years of senior finance

experience and was supported by a very experienced senior financial management team. The wider team possessed a broad range of skills and experience.

The finance team was accessible and responsive to NHSI requests. When required they kept them informed on key issues and had been quick to highlight potential risks, and to request support if necessary.

The trust was invited to a finance escalation meeting early in 2018/19 due to the adverse variance to plan reported in Month 3. Following that meeting the trust set about developing a recovery plan to recover the adverse variance and mitigate further pressures.

Despite the recovery actions taken the trust has failed to meet the financial control total for 2018/19. However, the plan had helped them to limit the scale of the loss compared to a worst-case scenario (which was a £15m variance to plan).

NHS Improvement had monthly meetings with the Director of Finance and Deputy Director of Finance to review financial performance and discuss the need for any specific actions to mitigate emerging concerns or realise potential opportunities.

The financial position of the trust improved between 2016/17 and 2017/18, largely due to a significant improvement reported by the former Staffordshire and Stoke on Trent Partnership Trust. This was driven by the removal of the adult social care contract, which had been a significant contributor to the £32.9m deficit reported in 2016/17.

The deterioration reported in 2018/19 was largely due to the merger, which had been delayed by two months. A combination of this slippage and the failure to deliver the immediate gains outlined in the business case contributed to the in-year deficit.

The trust expected to realise gains from efficiencies following the merger that would result in an improvement to the financial position over the next few years.

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

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
Child D	Shropshire IAPT	This SCR continues to be a live process. As yet, actions and recommendations are yet to be agreed.	N/A	N/A
SARE	Telford and Wrekin CMHT	This SCR continues to be a live process. As yet, actions and recommendations are yet to be agreed.	N/A	N/A

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 October 2017 and 30 September 2018, the trust reported 124 serious incidents. The most common type of incident was 'Apparent/actual/suspected self-inflicted harm' with 63 (51%).

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 comparable with STEIS with 124 reported.

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.

Type of incident reported	MH - Community based mental health services for adults of working age	CHS - Adult Community	MH - Mental health crisis services and health-based places of safety	MH – Wards for older people with mental health problems	CHS – Community Inpatients	MH – Other specialist services	MH - Acute wards for adults of working age and PICU	MH - Community-based mental health services for older people	MH - Secure wards/Forensic inpatient	CHS - Children, Young People and Families	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	43	-	12	1	-	4	-	2	1	-	**63**
Pressure ulcer meeting SI criteria	-	20	-	1	-	-	-	-	1	-	**22**
Slips/trips/falls meeting SI criteria	1	-	-	4	5	-	2	1	-	-	**13**
Failure to obtain appropriate bed for child who needed it	5	-	-	-	-	1	-	-	-	-	**6**
HCAI/Infection control incident meeting SI criteria	1	-	-	1	-	-	2	-	-	-	**4**
Treatment delay meeting SI criteria	-	1	-	-	1	-	-	-	-	1	**3**
Pending review (a category must be selected before incident is closed)	2	-	-	1	-	-	-	-	-	-	**3**
Abuse/alleged abuse of adult patient by third party	2	-	-	-	-	-	1	-	-	-	**3**
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	2	-	-	-	-	-	-	-	-	-	**2**
Apparent/actual/suspected homicide meeting SI criteria	1	-	1	-	-	-	-	-	-	-	**2**
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1	-	-	-	-	-	-	-	-	-	**1**
Medication incident meeting SI criteria	1	-	-	-	-	-	-	-	-	-	**1**
Commissioning incident meeting SI criteria	1	-	-	-	-		-	-	-	-	**1**
Total	**60**	**21**	**13**	**8**	**6**	**5**	**5**	**3**	**2**	**1**	**124**

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 October 2017 to 30 September 2018 were ‘Implementation of care and ongoing monitoring / review’, ‘Access, admission, transfer, discharge (including missing patient)’ and ‘Patient accident’. These three categories accounted for 10960 of the 18180 incidents reported. ‘Other’ accounted for eight of the nine deaths reported.

Ninety-four percent of the total incidents reported were classed as no harm (49%) or low harm (45%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Implementation of care and ongoing monitoring / review	301	6903	884	0	0	**8088**
Access, admission, transfer, discharge (including missing patient)	1229	198	16	1	0	**1444**
Patient accident	1114	283	31	0	0	**1428**
Medication	1091	107	3	0	0	**1201**
Infrastructure (including staffing, facilities, environment)	1035	56	1	0	0	**1092**
Consent, communication, confidentiality	733	71	3	0	0	**807**
Self-harming behaviour	698	76	15	0	0	**789**
Treatment, procedure	585	155	13	5		**758**
Disruptive, aggressive behaviour (includes patient-to-patient)	667	19	1	0	0	**687**
Other	479	59	8	2	8	**556**
Patient abuse (by staff / third party)	350	124	20	2	0	**496**
Documentation (including electronic & paper records, identification and drug charts)	297	23	1	0	0	**321**
Medical device / equipment	213	50	3	0	0	**266**
Infection Control Incident	63	110	15	0	1	**189**
Clinical assessment (including diagnosis, scans, tests, assessments)	52	4	2	0	0	**58**
Total	**8907**	**8238**	**1016**	**10**	**9**	**18180**

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).

Midlands Partnership NHS Foundation Trust (including Staffordshire and Stoke on Trent Partnership NHS Trust) reported more incidents from 1 October 2017 to 30 September 2018 compared with the previous 12 months.

Level of harm	1 Oct 2016 to 30 Sep 2017	1 Oct 2017 to 30 Sep 2018
No harm	9852 (56%)	8907 (49%)
Low	6682 (38%)	8238 (45%)
Moderate	1046 (6%)	1016 (6%)
Severe	15 (0.1%)	10 (0.1%)
Death	54 (0.3%)	9 (0.05%)
Total incidents	**17649**	**18180**

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 five ‘prevention of future death’ reports sent to Midlands Partnership NHS Foundation Trust. The trust had on each occasion provided a response to the coroner with assurance on preventing future risks.

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 said they had access to all necessary information and were encouraged to challenge its reliability.

The trust was aware of its performance using Key Performance Indicators and other metrics. This data fed into a board assurance framework. Both the trust risk register, and trust assurance plan were built upon information downloaded directly from the trust’s incident reporting and risk management system. This allowed easy cross referencing of risk summaries to the full detail of the risk and management plans.

Team managers had access to a range of information to support them with their management role through performance dashboards. This included information on the performance of the service, staffing and patient care. The safer staffing system gave real time information on patient needs, current staffing and predicted staffing requirements across the mental health wards.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. 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.

Information technology systems and telephones were working well within the trusts main buildings and hospitals and they helped to improve the quality of care. We heard some concerns about difficulties inputting training data and a record of appraisals into the electronic staff record. This had a potential impact on the assurance managers had that staff had completed training and appraisals satisfactorily. For instance, some data submitted to the CQC did not accurately report the training levels of staff regarding safeguarding.

Staff had access to the IT equipment and systems needed to do their work. Within some of the community services serving more rural areas staff told us they had problems remotely connecting to the central server which affected their ability to work remotely. The trust was piloting solutions to these problems and we heard some positive feedback from staff involved in the trial

There were some areas of specialist practice within the children, young people and families’ service that were still using paper records. They could access information from other disciplines on the electronic patient record. There was a programme to move all clinical records recording onto a single system by the end of 2019 and to allow access to all clinical staff.

Whilst this was welcomed by staff, we heard a concern from some who had transitioned from paper to electronic recording that only limited data had been transferred across to the new electronic systems. They believed this information on historic risk and treatments was not now accessible in a timely manner although they could make a request for archived patient notes.

Leaders submitted notifications to external bodies as required. The trust had made all necessary notification to external bodies and sought guidance from the CQC in understanding new responsibilities around adult social care services to ensure compliance. External stakeholders were positive about the trusts responsiveness to requests for information.

The trust had completed the Information Governance Toolkit assessment. Information governance systems were in place including confidentiality of patient records. The trust learned from data security breaches.

There was a holistic understanding of performance across all sectors. Within each care group there was a comprehensive assurance framework to allow managers to review data on performance and risk on a regular basis. The board received reports on overall performance of services within the trust against some common benchmarks.

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 March 2017 and February 2018, the trust only provided end dates for 81.6% 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 March 2017 and February 2018, the trust only provided end dates for 89.3% 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.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives across all sectors. The trust had remodelled its approach to service user engagement in 2016 and the resultant 'Involvement for Impact' model had been designed to involve the most appropriate service users in discrete improvement/change projects when needed. There remained regular service user engagement throughout the year, but we heard that the new structure of introducing focused Impact Workshops had worked well.

On example of the ongoing engagement and involvement of service users in designing and in part providing a service was in the development of the trust's well-being and recovery college. Across both Staffordshire and Shropshire, the college ran classes led by current and ex mental health service users in co-production with staff. The future development of the college and its curriculum was driven by the feedback and shared learning from the involvement of service users attending its classes.

The positive engagement of service users within the mental health services was reflected in very positive results in key questions within the 2018 Community Mental Health Survey.

- The trust scored 8.4 out of 10 for patients having been told who oversaw organising their care and services, which was better than the average range of 6.4 to 8.4 out of 10.
- The trust scored 8.7 out of 10 for patients feeling they were treated with respect and dignity by NHS mental health services, which was better than the average range of 7.9 to 8.6 out of 10.
- The trust scored 7.6 out of 10 for patients having been involved as much as they wanted to be in decisions about which medicines they receive, which was better than the average range of 6.5 to 7.5 out of 10.
- The trust scored 7.7 out of 10 for patients having had a member of their family or someone else close to them involved as much as they would have liked, which was much better than the average range of 6.2 to 7.3 out of 10.

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 had also rolled out the use of a staff huddle into most patient areas. A huddle was an informal meeting of staff to review risk, demand and progress on innovations within the service. They had been introduced to supplement more formal handovers and had a common agenda set out on an activity (huddle) board in each clinical area.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Feedback was gathered through patient surveys as reported, above and informally through compliments and the completion of the friends and family test.

The trust sought to actively engage with people and staff in a range of equality groups. Within their public and staff engagement events in the last year, the trust had held a series of targeted events to gain the opinions of local minority communities and staff from diverse backgrounds inside the trust.

The trust offered public Governors, training on appointment. They were actively involved in the operation of the trust. We attended a council of Governors meeting and subsequently spoke with individual governors. As a group, the Governors were very active within the trust supporting executive members in quality visits to clinical sites. They had been closely involved in discussions around the merger and the director of strategy regularly briefed them on progress. They had clear understanding of their responsibilities and had an effective oversight of the non-executive board members.

The trust had a structured and systematic approach to staff engagement. Through their programme of listening into action events the trust regularly engaged with staff about the services they worked within. This meant staff were involved in decision making about changes to the trust services. We heard in focus groups of staff in the community health adult services being involved in a programme of meetings with senior leaders around developments of the service.

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. As well as regular public engagement events trust leaders had a role in several developmental and consultation groups during the creation of MPFT through the integration of the community health services previously run by Staffordshire and Stoke on Trent Partnership trust. These included engagement around implementation of the accessible information standard, the involvement of deaf people and health inclusion groups focused on local Black and minority ethnic communities.

Division leaders/middle managers, on behalf of front-line staff, engaged with external stakeholders such as commissioners and Healthwatch.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. It hosted the development team for one of the two local sustainability and transformation plans. Board members led on key work streams for developing the local health community.

External stakeholders said they received open and transparent feedback on performance from the trust. We spoke with representatives of NHS Improvement and the clinical commissioning groups in Shropshire and Staffordshire. They told us that the trust worked with them in joint quality reviews or oversight panels and provided all the information and assurance they needed. However, in two areas within Shropshire we heard of difficulties in accessing performance data for some services in the initial period following the transfer of services to the trust. The trust had acted to improve the quality of information available in line with the commissioners' expectations.

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. Across the mental health wards for older adult's core service we found staff were able to report on successful local initiatives and these are highlighted in our summary of outstanding practice.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning.

The trust was actively participating in clinical research studies. The trust had a dedicated research and innovation department that led a very active research programme for clinicians in both mental health and community services. With two local universities, they were involved in service evaluation and primary research. Their success had been recognised at the Clinical Research Network (CRN) West Midlands awards in 2018. The Shropshire sexual health research team won the collaboration in research award, while the Shropshire dementia research team won in the emerging new team category.

There were organisational systems to support improvement and innovation work. A centralised quality improvement team could provide support to staff in clinical and other areas to take forward quality initiatives.

Staff had training in improvement methodologies and used standard tools and methods. In the Quality Account for 2017/8 it is reported that 1000 staff across the organisation had received training in quality improvement methodologies and that ongoing training of frontline staff and managers was continuing. The trust had adopted the Virginia Mason Production System, as its preferred methodology. The focus was on promoting local initiative as much as possible and there was training and support for team leaders and clinicians to become leaders in quality improvement, enabling their teams to practice quality improvement within their own services.

There was further specialist quality improvement training available for senior leaders in the organisation so that they could be sponsors to and support long-term, wide ranging quality improvement programmes. This higher-level training was mandatory for executive level staff.

Effective systems were in place to identify and learn from unanticipated deaths. There had been robust processes in place to review each unexpected death within the mental health services that had been the core business of South Staffordshire and Shropshire Healthcare NHS Foundation Trust. This had included involvement in national initiatives around learning from deaths such as the learning disabilities mortality review (LEDER) project. The scope and scale of reporting around unexpected deaths had increased significantly with the acquisition of community health services in Staffordshire and Stoke.

Within that care group a mortality review board had been placed to monitor trends and identify themes for action within the much larger number of reported deaths seen within those services. These processes remained in place until the Integrated Mortality review panel was established in March 2019. This panel looks at natural cause deaths across the whole of the Trust both physical health services and mental health, Learning Disabilities and specialist services.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. Many teams we visited had ‘huddle boards’ in place. They contained information the team needed to discuss improvement activities, this embedded discussions around quality into everyday practice. There was very positive feedback from staff about the use of the huddles to share information across the multi-disciplinary teams and record progress on local initiatives. For example, on the older adult wards at the Redwoods Centre, the huddle board reflected progress in implementing their falls prevention work.

External organisations had recognised the trust’s improvement work. Individual staff and teams received awards for improvements made and shared learning. Amongst them in 2018 was first place in the Nursing Times award for innovation in the community management of chronic wounds.

Staff were aware of their contribution to cost improvement objectives.

Staff used data to drive improvement. Staff involved in the rapid process improvement workshops received ongoing updates from the quality improvement team of the effectiveness of their innovations.

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 (trust-wide only) and the relevant dates.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
AIMS – WA (Working Age Units)	Acute wards for adults of working age and psychiatric intensive care units	Brocton Ward Chebsey Ward	January 2017 6 March 2018
AIMS – PICU (Psychiatric Intensive Care Units)	Acute wards for adults of working age and psychiatric intensive care units	Norbury	March 2017
AIMS – OP (wards for older people)	Wards for older people with mental health problems	Holly Oak	February 2016 March 2018
Quality Network for Forensic Mental Health Secure Services (Low and Medium)	Secure wards/Forensic inpatient	5 & 6 December 2017 - Full Review Medium Secure achieved: 89% of secure standards met Ellesmere House - Low Secure LD achieved: 90% of secure standards met 16 January 2018 - Full Review Clee - Low Secure achieved: 96% of secure standards met The Directorate is at mid-term QI Review with MSU - awaiting formal report. LSU/LD being undertaken on 4 December 2018 and Clee LSU due 22 January 2019	
UNICEF Baby Friendly accreditation for infant feeding and early parenting	CHS – Children Young People and Families	Health Visiting Service	2015. Reaccredited in October 2017
Quality Network for Perinatal Mental Health Services (QNPMH)	Not provided	Brockington MBU	Re-accredited until October 2020
ECT Accreditation Scheme (ECTAS)	Not provided	Redwoods Centre – 5 September 2017 St Georges Hospital – 13 June 2017	
Psychiatric Liaison Accreditation Network (PLAN)	MH - Community-based mental health services for adults of working age		RAID – PRH RAID - RSH Liais Adult West South Staffs LIAS Adult East South Staffs

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
			The above teams are engaged with the scheme but have not yet achieved accreditation
Home Treatment Accreditation Scheme (HTAS)	MH - Mental health crisis services and health-based places of safety		CRHT West CRHT East CRHT Telford and Wrekin CRHT Shropshire The above teams are engaged with the scheme but have not yet achieved accreditation

Community health services

Community health services for children, young people and families

Facts and data about this service

Information about the sites and teams, which offer community health services for children, young people and families at this trust, is shown below:

Location Name	Team Name	Services provided
Beecroft Court	SALT – Cannock G02754	Speech & Language Therapy Services (Children)
Beecroft Court	SALT Education West G02755	Speech & Language Therapy Services (Children)
Bentillee Neighbourhood Centre	Child Nth City Health Visiting G02865	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Bentillee Neighbourhood Centre	School Readiness G03973	Part of Stoke Speech and Language Therapy Service
Cannock Chase Hospital	Paediatrics Podiatry G02742	Podiatry
Civic Centre, South Walls, Stafford, ST16 3AQ	0-19 Stafford & Surrounds G02766	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal

		and targeted interventions for children and their families.
Cobridge Community Health Centre	Community Breast Feeding Team G03098	Infant Feeding, Community Support,
Codsall Clinic, Elliots Lane, Codsall, WV8 1PH	0-19 Seisdon & Surrounds G02740	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Colliery practice Cannock	0-19 Colliery Practice	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Duke Street, Fenton	Child Nth Occupation Therapy G02914	Occupational Therapy
Duke Street, Fenton	Child Nth Physiotherapy G02879	Physiotherapy
Duke Street, Fenton	Child Nth County CCN G02887	Children's diabetes nursing team
Gnosall Surgery	0-19 Gnosall	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Hanford Health Centre	Child North County CCN	Providing care for children in the community setting, including the home, who would otherwise need to be in hospital
Hill Street Health & Well Being Centre, Burton	SALT East G02736	Speech & Language Therapy Services (Children)
Hill Street Health & Well Being Centre, Burton	SALT Education East G02737	Speech & Language Therapy Services (Children)
Lanxess House	Paed LD South Staffs - East	Group of professionals, providing medical and non-medical outpatient and community services. The service provides child protection medicals, advice to Fostering and Adoption Panel and expert lead in immunisation. Secondary, specialist and community services are provided for children with health and development needs, offering assessment, investigation, therapy and, where applicable; treatment. In partnership with parents, staff also support the follow-up and management of children with special needs, including children with complex disabilities and for those who need help with behaviour related to their disability.
Leek Health Centre	0-19 Moorlands G03436	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Norton Canes Health Centre	0-19 Cannock & Rugeley G02753	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal

		and targeted interventions for children and their families.
Samuel Johnson Hospital, Lichfield	Paediatric Physio East G02738	Physiotherapy
Shelton Primary Care Centre	Public Health Advisory Service G03906	Working in partnership with schools and other professionals, we offer support to children and young people with SEND in various ways. 5 - 19 years contract
Shelton Primary Care Centre	CYP Targeted Intervention Service G03426	Working in partnership with schools and other professionals, we offer support to children and young people with SEND in various ways. 5-19 years contract
Silverdale Medical Centre, Vale Pleasant, Silverdale, Newcastle ST5 6PS	0-19 Newcastle G02873	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Rising Brook Health Centre health & Wellbeing Centre, Rugeley	School Age Immunisation Team G02756	School Age Immunisation Team
St Chad's Health Centre, Dimbles Lane, Lichfield, WS13 7HT	0-19 Lichfield & Burntwood G02764	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Stafford Central Clinic, Stafford	Dietetics Stafford G02759	Community Dietetics service for children and young people
Stafford Central Clinic, Stafford	Paediatric Physio West G02743	Physiotherapy
Stafford Central Clinic, Stafford	SALT Stafford G02758	Speech & Language Therapy Services (Children)
The Bridge	Paed LD South Staffs - West	Group of professionals, providing medical and non-medical outpatient and community services. Secondary, specialist and community services are provided for children with health and development needs, offering assessment, investigation, therapy and, where applicable; treatment. In partnership with parents, staff also support the follow-up and management of children with special needs, including children with complex disabilities and for those who need help with behaviour related to their disability.
Trentside Clinic, Stafford Road, Stone, ST15 0TT	0-19 CPE/Specialist County G03452	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
Tutbury Health Centre	0-19 Burton G02761	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.

Wilnecote Health Centre	0-19 Tamworth G02772	Coordinate and deliver the healthy child programme in Staffordshire. Contributing to improving health and wellbeing outcomes for children and young people, identifying additional needs early, building resilience and reducing health inequalities by providing effective universal and targeted interventions for children and their families.
56 High Street, Burton-On-Trent	Children's Community East	Offer care for children in the community setting, including the home, who would otherwise need to be in hospital.
Stafford County Hospital	Children's Community West	Offer care for children in the community setting, including the home, who would otherwise need to be in hospital.
Lanxess House	Paed CHC South Staffs - East	Group of professionals, providing medical and non-medical outpatient and community services. Secondary, specialist and community services are provided for children with health and development needs, offering assessment, investigation, therapy and, where applicable; treatment. In partnership with parents, staff also support the follow-up and management of children with special needs, including children with complex disabilities and for those who need help with behaviour related to their disability.
The Bridge	Paediatric Continuing Healthcare (CHC) South Staffs - West	Group of professionals, providing medical and non-medical outpatient and community services. Secondary, specialist and community services are provided for children with health and development needs, offering assessment, investigation, therapy and, where applicable; treatment. In partnership with parents, staff also support the follow-up and management of children with special needs, including children with complex disabilities and for those who need help with behaviour related to their disability.
Saxon Hill Community School	Staffordshire Special School Nursing Service	School nursing team supporting Special Schools
Trent Valley Road, Lichfield	Community Complex Care Team	provides services for children and adults who have continuing complex healthcare needs, including technology dependence

(Source: Provider Information Return: Sites)

Is this service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received a trust and local induction when they started in their roles. Completion rates for mandatory training was high across most services. Where there were gaps in compliance, there were plans in place to ensure completion and reviews in a timely manner.

Staff completed mandatory training in a range of competencies required for their roles. The mandatory training programme included but was not limited to infection prevention control, moving and handling, basic life support and safeguarding adults and children up to level three and level four those who required it. Staff were notified electronically when they were required to complete and update their mandatory training. Compliance was overseen and managed by the leadership team. This meant there was a robust system to ensure staff had key skills for their role with scheduled updates to maintain competencies.

The trust set a target of 90% for completion of mandatory training.

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Mental Health Act	1	1	100%	90%	Yes
Promoting Safer and Therapeutic Services	13	13	100%	90%	Yes
Manual Handling - Object	47	48	98%	90%	Yes
Local Induction	552	571	97%	90%	Yes
Corporate Induction	541	555	97%	90%	Yes
Mental Capacity Act Level 2	592	623	95%	90%	Yes
Prevent Awareness	542	571	95%	90%	Yes
Safeguarding Children (Level 3)	469	495	95%	90%	Yes
Conflict Resolution	475	509	93%	90%	Yes
Health and Safety (Slips, Trips and Falls)	515	555	93%	90%	Yes
Safeguarding Adults (Level 1)	524	566	93%	90%	Yes
Safeguarding Children (Level 2)	519	566	92%	90%	Yes
Equality and Diversity	518	571	91%	90%	Yes
Adult Basic Life Support	449	510	88%	90%	No
Infection Prevention (Level 1)	436	503	87%	90%	No
Information Governance	495	571	87%	90%	No
Clinical Risk Assessment	11	13	85%	90%	No
Fire Safety - 1 Year	480	571	84%	90%	No
Medicine management training	10	12	83%	90%	No
Manual Handling - People	394	512	77%	90%	No
Total	**7583**	**8336**	**91%**		

In community health services for children, young people and families, the 90% target was met for 13 of the 20 mandatory training modules for which staff were eligible.

Safeguarding

Staff understood how to protect patients from abuse and had training on how to recognise and report abuse.

Staff received appropriate safeguarding training in safeguarding adults and children. The level of training was determined by role and responsibility. For example, health visitors and school nurses received level 3 safeguarding training. This was in line with the intercollegiate guidance Safeguarding Children and Young People: Roles and Competencies for Health Care Staff published in March 2014 (updated and re-publishedrepublished in January 2019).

Staff could access a safeguarding team based in the local multi-agency safeguarding hub (MASH) team for specialist and multi-agency support. The MASH was a partnership between six key public sector organisations who covered the county of Staffordshire and the city of Stoke-on-Trent. Professionals from health and social care and criminal justice worked together to improve safeguarding outcomes for children. with care and support needs. There iswas a named nurse for children safeguarding in line with Working Together to Safeguard Children (2018) and NHS England Accountability and Assurance Framework (2015).

Safeguarding advice and support were accessible to staff. Staff told us that the safeguarding team could be accessed directly by telephone or email. The team's details were displayed on a dedicated safeguarding intranet page. An up to date policy was accessible on the safeguarding page. There were links to support staff who kept up to date with safeguarding information and training. There were a wide range of training and development opportunities relating to

safeguarding, which were provided by the local safeguarding children board. This meant all the information relating to safeguarding was accessible from one place.

Staff provided us with documented examples of when they sought support from staff at the multi-agency safeguarding hub (MASH). This helped them safeguard people who used the service. Safeguarding documentation was uploaded and accessible on the electronic recording system. This meant that all staff with the right to do so could access this information. There was scope on the system to only allow the information to be shared with certain people and for information to be hidden. This meant confidentiality was protected and associated risks were reduced.

The leadership team supported staff to access safeguarding supervision with named nurses. This could happen face-to-face on a quarterly basis. Safeguarding staff were always available on the telephone. We reviewed data relating to the high number of calls that came through to the safeguarding team from staff. We saw staff were using the team to support them with safeguarding queries and concerns on a frequent basis. Staff based at the safeguarding hub told us they had good relationships with locality social workers and they knew where to find help if they required it. This met statutory requirements and promoted safe practice across the health economy.

Children and young people with specific physical and emotional health needs had their needs met. They were referred to the appropriate child and adolescent mental health service, a school counsellor or a trusted adult from the school. School nurses also offered a drop-in clinic. All related information could be uploaded in to child records. Records were safely stored to avoid unauthorised access. School nurses referred children and young people with physical health needs to the targeting intervention service.

Safeguarding staff shared information with relevant agencies. For example, when child sexual exploitation was identified or when a family were involved in a multi-agency risk assessment conference. Staff could attend these safeguarding panels for development.

Safeguarding staff attended strategy meetings when female genital mutilation had been identified or if a child was at risk. Staff had access to female genital mutilation training.

Staff told us they referred and signposted children and young people to local services for additional support. For example, services for people with gender identity concerns. One staff member told us they had recently completed a NSPCC sexualised behaviour course. This meant that staff were suitably trained to deal with complex issues relating to specifically to children and young people.

The trust set a target of 90% for completion of safeguarding training.

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion (%)	Trust Target	Target met (Yes/No)
Safeguarding Children (Level 3)	469	495	95%	90%	Yes
Safeguarding Adults (Level 1)	524	566	93%	90%	Yes
Safeguarding Children (Level 2)	519	566	92%	90%	Yes
Total	**1512**	**1627**	**93%**	**90%**	

Safeguarding Referrals

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 at risk from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority had 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.

Community health services for children, young people and families made 61 safeguarding referrals between 1 October 2017 and 30 September 2018, all of which concerned children.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Cleanliness, infection control and hygiene

Overall, the service controlled infection risk well. Staff largely kept themselves, equipment and the premises clean. Staff used control measures to prevent the spread of infection.

Staff completed mandatory infection prevention control training at regular intervals. The figures for completion was high. Leaders told us that there were infection prevention control leads and there were audits to ensure staff were compliant. This was in line with best practice to reduce the spread of infections.

However, staff could not always access the right resources to help with infection prevention control. For example, sinks with hot running water and hand wash facilities where baby clinics were held. The risk had been identified as a risk in the risk register with mitigation planned. Staff kept contact with baby to a minimum, used the nearest sinks and carried hand gels and antibacterial wipes to reduce the risk of spreading infections.

Staff did not always follow infection prevention control principles. We saw some nurses carrying out clinical work wearing painted nails and they were not always bare below the elbow during clinical exchanges with clients. In one clinic we did not see anyone wash their hands. One child had a highly infectious virus and we saw staff using hand gel rather than a more effective way to avoid spreading the virus to others, for example, with hot water and soap.

All clinical areas we visited were visibly clean. There were daily cleaning rotas which confirmed all areas had been cleaned at the required frequency, for example, daily or weekly. Staff provided people who used the services with clean equipment and toys. To avoid and reduce the risks of the spread of infection, there were completed rotas and checking systems to ensure toys were cleaned.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Staff had access to and carried with them suitable equipment. For example, we saw there was a supply of syringe drivers accessible to the palliative care and hospital at home team. We looked at calibration records and portable appliance testing. Calibration is when equipment is tested to ensure it provides accurate measurements. Portable appliance testing is a process by which electrical appliances are routinely checked for safety. This meant there were processes in place to ensure the safety and accuracy of equipment.

We inspected the service during the school holidays and were unable to inspect the environment and equipment held at school for children with healthcare needs. However, we spoke with staff physiotherapists who worked with children with cerebral palsy. These staff told us they had the equipment required to meet the needs of the children and young people in the community. They had access to spares and the equipment was checked to ensure it was safe to use.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient. Records did not always contain complete risk information to ensure staff could access appropriate risk information at the right time.

Staff did not always carry out formal comprehensive risk assessments in line with national guidance. The hospital at home team did not always record risk information within patient records. Some risk information was contained within assessment paperwork and sometimes there were risk markers on the electronic system to flag risks to staff. Some care records had no risk information. There were some examples of good risk assessment, for example, at the 0-19 service and physiotherapy staff used a risk matrix to needs assess. The 0-19 used the perinatal suicide and self-harm risk management pathway. This meant that some risks were being well managed, while others may not be adequately assessed.

Staff we spoke with were mindful of risks but could not be assured that the risks were always identified prior to contact. Staff used various methods to assess risk. For example, baby clinic staff considered safety practically. We saw staff had put tables against walls and chairs at each side to avoid falls. One nurse told us they constantly assessed dynamic risks. When risks were identified, an alert should be put on progress notes. We observed a nurse follow up on an alert indicated on electronic records in advance of a home visit. This meant that that staff did think about risks and the impact of staff and those who used the service.

Clinical staff had the skills, training and qualifications to assess physical health concerns. If a physical health concern was identified, staff would either refer the patient to their GP, send families to urgent care, or if appropriate ring 999. Staff provided us with examples of when they had assessed a patient who required onward referral to their GP and when they had to use emergency services.

Staff did not have mandatory training around sepsis. Staff had an awareness of sepsis and could access sepsis information on the trust intranet. The expectation was they would be following the guidelines. We had no information or data relating to the incidence of sepsis in this service.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staffing levels compared well to what was planned. Senior staff identified staffing requirements. Some services operated a caseload management model to keep people safe and have access to a responsive service. For example, the 0-19 service was remodeled to work as a Hub, with qualified staff who could respond to people's needs swiftly. Baby clinics used a traffic light system to help them adequately staff the service. Where possible agency use was avoided, instead, bank staff were used which meant they were staff who were already employed by and familiar with the trust.

Palliative and complex care team and hospital at home had 22 whole time equivalent staff at varying bands. The children and young people's diabetes service employed nine whole time equivalent staff. An epilepsy specialist nurse was employed to support the service and was based at another local NHS trust. A community respiratory nurse sat within children's community nursing team but only covered the Stoke on Trent area for asthma. In addition, there was a quality nurse whose role was around quality and process.

There were three team leaders who covered geographical patches that mirrored local authority commissioning areas. There was a targeted intervention service with 12 whole time equivalent staff and a public health advisory service. This service was overseen by a team leader, twelve school nurses and practice teachers. There were a team of five whole time equivalent community breast feeding staff to cover this service.

Following a management of change process to create the new 0-19 service there had been significant changes in the balance between school nurses and health visitors within the service. There was a development programme in place supported by the practice teachers to ensure remaining staff would have the competencies of both specialist roles.

There were a team of community paediatric physiotherapists. The team was led by two team leaders and included 16 whole time equivalent physiotherapy staff and nine whole time equivalent occupational therapists and speech and language therapists.

Details of staffing levels within community health services for children, young people and families as of March 2018 and September 2018 are below.

	March 2018			September 2018		
Site	**Actual staff – WTE**	**Planned staff – WTE**	**Fill Rate**	**Actual staff – WTE**	**Planned staff – WTE**	**Fill Rate**
56 High Street Burton-On-Trent	4.3	4.3	100.0%	8.2	7.9	96.3%
Beecroft Court	9.7	9.9	101.3%	9.7	8.4	85.9%
Bentillee Neighbourhood Centre	86.3	84.9	98.4%	89.4	86.2	96.5%
Cannock Chase Hospital	1.6	1.6	100.0%	2.1	1.8	87.8%
Civic Centre South Walls Stafford	22.8	20.5	89.8%	22.6	24.2	107.2%
Cobridge Community Health Centre	4.8	4.6	95.1%	4.8	3.8	78.4%
Codsall Clinic	17.0	16.7	98.1%	16.9	15.6	91.9%
Colliery practice Cannock	2.2	2.2	100.0%	2.2	1.6	72.7%
Duke Street, Fenton	52.0	45.3	87.1%	52.8	45.3	85.9%
Gnosall Surgery	1.0	1.0	100.0%	1.0	1.0	100.0%
Hanford Health Centre	8.8	8.2	92.6%	7.8	8.2	104.7%
Hill Street Health & Well Being Centre, Burton	19.2	16.4	85.6%	18.4	18.8	102.4%
Lanxess House	34.9	32.5	93.0%	40.2	33.6	83.6%
Leek Health Centre	16.9	15.3	90.7%	17.4	17.1	98.2%
Norton Canes Health Centre, 41 Brownhills Road, Norton Canes, Cannock, WS11 9SE	21.8	18.8	86.1%	20.1	19.4	96.7%
Samuel Johnson Hospital, Lichfield	10.3	9.7	94.1%	10.5	10.7	101.6%
Saxon Hill Community School	0.0	0.0	-	0.0	14.7	-
Shelton Primary Care Centre	38.6	32.9	85.1%	38.5	35.8	92.9%
Silverdale Medical Centre	22.4	21.3	95.0%	20.8	22.5	108.1%
Rising Brook Health Centre	18.5	14.7	79.7%	24.5	13.2	54.1%
St Chad's Health Centre	18.0	15.6	86.5%	18.3	17.9	97.4%
Stafford Central Clinic	67.5	58.4	86.5%	61.2	50.8	83.1%
Stafford County Hospital	9.8	8.8	89.8%	9.2	7.8	84.8%
The Bridge	29.6	25.4	85.7%	24.6	21.0	85.2%
Trentside Clinic Stafford Road	5.0	4.7	94.9%	11.4	7.7	67.3%
Tutbury Health Centre	25.3	23.7	94.0%	23.8	26.3	110.4%
Wilnecote Health Centre	18.0	17.0	94.3%	19.0	20.2	106.5%
Grand Total	**566.3**	**514.2**	**90.8%**	**575.2**	**541.2**	**94.1%**

Vacancies

The trust set a target of between 8% and 12% for vacancy rate. From October 2017 to September 2018, the trust reported an overall vacancy rate of 7% in community health services for children, young people and families. This met the trust's target. The vacancy rate for nursing staff was -7% (over establishment); for medical staff it was 15% and for allied health professionals was 10%.

A breakdown of vacancy rates by staff group in community health services for children, young people and families at trust level and by team/site is below:

Staff group	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
NHS infrastructure support	24.8	16.3	66%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	2.1	1.1	52%
Support to ST&T staff	28.5	4.6	16%
Medical & Dental staff - Hospital	12.0	1.8	15%
Support to doctors and nursing staff	197.5	28.1	14%
Qualified Allied Health Professionals (Qualified AHPs)	105.3	10.9	10%
Qualified Healthcare Scientists	2.0	0.0	0%
Qualified nursing & health visiting staff (Qualified nurses)	275.8	-19.9	-7%
All staff	**647.9**	**42.8**	**7%**

Suspensions and supervisions

During the reporting period from October 2017 to September 2018, community health services for children, young people and families reported that there were no cases where staff have been either suspended or placed under supervision.
(Source: Universal PIR P23 Suspension or supervised)

Quality of records

Staff kept records of patients' care and treatment. The quality of records was variable. They were not always clear, up-to date and available to all staff providing care.

Staff had access to an electronic record system. They were issued with laptops, so they could use the technology while out in the community or in the office. Staff were supported with technology to allow them to access patient records electronically and make entries at point of contact where possible. This meant, in theory, all staff should always be able to access patient information.

There were ongoing issues with merging the hard copy and electronic record system. There were a high number of records to go to storage. There were records outstanding for scanning. This meant that staff could not always access everything they needed in a timely manner.

All staff we spoke with told us there were connectivity issues. This meant they could not always access the right information at the right time. Work was being carried out by technical staff to try to resolve the issues. The new system had not been fully implemented at the time of the inspection. There were two different versions of the electronic system. This was on the risk register and there were plans to merge by the end of December 2019. Staff mitigated against any potential risks by liaising between services. Staff told us they assessed access to information in advance to ensure, where possible, they had what they needed. Staff could also contact colleagues if needed to gain information. Staff could upload information when they were in a place where there was connectivity.

The records we reviewed did not always contain up to date information. The hospital at home service did not always have completed records for the referrals they took. For example, when answering a parent's query in one telephone call; progress notes would be updated in those instances. Some staff provided clear, comprehensive and detailed records. For example, the physiotherapy team records were of high quality as they included good quality information about people.

All records were stored securely on the computer system. Any hard copy information was secured in a locked cabinet, accessible only by those who had permission. Staff considered patient confidentiality and information governance to avoid breaching associated guidelines.

The leadership team had a process to ensure there was regular oversight of records to improve practice. They carried out monthly record keeping audits with action plans to ensure information was accurate and good quality. The service was in the process of redesigning records auditing to make it more electronic specific and allow better manipulation of the data to help with quality. This included safeguarding records to share where a child had needs including child protection. Staff knew and understood the system and process for accessing any shared safeguarding information.

Medicines

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication, at the right dose, at the right time.

Staff did not routinely administer medicines. For example, the nurses who supported the constipation service were not prescribers. Patients accessed medication through their GP's. Health visitors used medicines minimally. Any medicines taken on visits and clinics, for example medicines for oral thrush and nappy area thrush, were safely stored and transported to keep people safe. Where medicines were administered, staff ensured it was in line with relevant legislation, national guidance and best available evidence.

Staff received training in the safe management of medicines. Staff who were responsible for the administration of medication using syringe drivers had additional training. This meant they received specialist training to administer medication using this route.

Arrangements for managing medicines and medical gases kept people safe. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal. Medicines storage and controlled drugs were audited. We saw documentation of action plans to address issues identified through these audit processes.

When allergies were identified they were clearly documented in the prescribing documentation and on the electronic record system. Staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council – Standards for Medicine Management.

Safety performance

Staff monitored performance using an electronic recording dashboard system. Staff entered information relating to safety and could access real time reports.

Incident reporting, learning and improvement

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. When things went wrong, staff apologised and gave patients' honest information and suitable support.

Staff had access to an incident reporting system and understood the process for reporting. Themes and selected incidents were shared in team meetings to learn lessons and improve practice. All staff had incident reporting training and could only access the system to report incidents when the training was complete. The system had a built-in feature to halt the process if there were any omissions. A copy of all incidents was sent to a manager for sign off and to determine next steps.

All managers had the authority to pull data based on location, team and themes. Managers monitored the system to assess how many incidents had been recorded, completed and how many remained outstanding. We were provided with examples of types of incidents reported and when the information was used to support safety. For example, themes around safety of lone working staff. A buddy system was set up. All staff could access electronic diaries. Community

children's nurses were allocated lone worker devices. The devices allowed instant communication in the event of an emergency. Staff risk assessed and where possible, went out in pairs.

Staff provided us with numerous examples of when they had reported incidents, how they had been processed and the outcomes. We were provided with examples of information governance incidents where actions to improve practice had been identified and shared with staff. In some instances, feedback was only shared with the reporter. Where appropriate, feedback was also shared with people who used the service.

Staff knew and understood the principles of Duty of Candour. All staff were trained in Duty of Candour. A risk team ran trend reports from the electronic system to gather themes relating to Duty of Candour. Staff could provide us with examples of when a theme was identified and when Duty of Candour had been discharged to the family. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no never events for community health services for children, young people and families.

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in community health services for children, young people and families, which met the reporting criteria, set by NHS England between, October 2017 to September 2018. This incident was categorised as 'Treatment delay'.

The number of the most severe incidents recorded by the trust incident reporting system is the same as that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Is this service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff assessed people's needs in a holistic way. Staff looked at physical, mental health and social needs which was in line with best practice. The service delivered the healthy child programme which included vaccination programmes. Children who engaged with the palliative care team had personalised, up to date plans of care which were in line with best practice. People with complex needs received a multidisciplinary approach to meet their needs. For example, staff within the service engaged with the local authority health and social care staff and mental health services to meet those needs.

Staff used National Institute for Health and Clinical Excellence (NICE) guidance to develop policies. We saw this evidenced within policies. For example, policies for antenatal and post-natal mental health. Staff told us they identified statements of best practice to support children

transitioning between paediatric to adult services. The trust's Statement of Purpose documents referenced the use of NICE guidance in their development.

Speech and language therapy staff used a risk matrix they had developed to determine level of service required. For example, the higher the risk score the more service required. Care aims was used to set goals for families. This tool was in the process of being adapted for the use of all professionals across the service.

Professional leads were key to service delivery and were actively involved in tenders and service development. For example, leads from the 0-19 school nursing and health visiting were active in the set up. Leads held meetings with staff to encourage input from all involved. All team leaders were senior clinicians and engaged in professional bodies and regional boards.

Services were setup and delivered based on evidence-based guidance. For example, the 0-19 service was devised to deliver the healthy child programme. Staff contributed to accreditation schemes. For example, the United Nations International Children's Emergency Fund's Baby Friendly accreditation. The service had received Gold level. The award was designed for acknowledge services whose audit results consistently showed the Baby Friendly standards were largely being met.

Staff from varying disciplines had access to outcome measuring tools and the professional code of practice relating to their field. Heath visitors had an outcome measuring tool for internal use. They utilised a progressive scale to allow professional and client to score progress made so demonstrating the progress of the child in discreet steps It was motivational in its approach and encouraged families taking responsibility. Staff were familiar with Special Educational Needs and Disability (SEND) code of practice and were in process of developing their own guidelines. There were provider network champions who met quarterly to monitor and review progress.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Staff routinely gathered and monitored information about the outcomes of people's care and treatment to learn how to make improvements. The information showed the intended outcomes for people were largely being achieved. Staff participated in many relevant local and national audits. There was evidence of benchmarking, and accreditation. Information about people's outcomes was used to make improvements.

Staff used audit tools to monitor and improve outcomes. For example, physiotherapy staff used therapy outcome measure tool. We looked at data and reports relating to various services following audits. For example, the Stoke on Trent community breastfeeding service. A key performance indicator for this service was that breastfeeding staff visited post-natal wards daily. This was to engage all breast-feeding mothers within 48 hours of delivery. The service was promoted in health centres, GP surgeries, social media, including Facebook and twitter.

Staff were trained to deliver a tongue tie (frenulotomy) service in the community. This was commissioned by the local authority Stoke City Council. Staff understood the key performance indicators and outcomes were good. We looked at up to date dashboards with key performance indicators. Where any targets were not met, this was indicated. For example, in November 2018 there were staff shortages and a high number of referrals which meant not all patients were offered an appointment within five working days. In December 2018 there was a reduction in clinics over Christmas period. Managers could use this information to develop a recovery plan to ensure patient flow was improved again.

People could access a helpline facilitated by a team of health visitors. We looked at figures over the previous six months, the highest number of calls received in October 2018 which was 159. We looked at the live call monitoring system while we were on site. There had been 42 calls in a two-hour period. Waiting times for callers was recorded. The longest wait for callers in this period was

one minute. A daily log was kept, and the data was audited weekly for themes. The system also allowed staff to see how many calls were received from professionals, for example in October 2018, 60 of the calls received were from professionals.

The trust had participated in six clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
Child Protection Reports Audit	South Staffs Paediatricians (The audit examined child protection reports)	The overall compliance against the standards achieved 88%, an improvement from the previous audit (79%). 13 of the 15 standards showed improvements or remained at 100% compliant compared with the previous audit. There were significant improvements when filling in the 'Findings' section of the report and recording the name, date of birth and NHS number on every page.	Report shared with individual paediatricians. This was followed up with individual discussions with Designated Doctor for Safeguarding Children. Overall results discussed at paediatricians monthly meeting. Discuss and agree how all paediatricians describe injuries and summaries their report. Report shared with clinical leads and Business Managers to liaise with the admin staff through business support managers to ensure 100% documentation of bio-data on every page of CP report.
Initial Health Assessment	East Paediatrics + West Paediatrics	The audit demonstrated overall good compliance against the LAC initial health assessment checklist and the target of 10 working days for completion of the report. Overall compliance increasing from 73% to 81%.	The process for consent has been updated and agreed with the Social Work team. Consent is now completed on the medical form prior to assessment request by the Social Worker. Forms/requests without consent are returned for completion before assessment can take place. Training is being provided to relevant paediatric staff. Results of the audit will be highlighted to emphasise/re-enforce any areas of 'low compliance'.
Re-audit of Diarrhoea and Vomiting in Children Under 5	Community Children's Nursing Team - West	The overall compliance of the re-audit has stayed consistent with the previous audit at 86%. Overall the audit showed the team are following NICE guidance to a high standard with 3 of the applicable standards meeting 100% compliance.	Staff to become pro-active when parents/carers do not provide e-mail address to send information leaflets via post, so they have the relevant information to help care for the child's needs Staff to document when the ORS is given by other professionals in the child's health record (i.e. GP), so there is a valid reason why MPFT staff have not administered ORS. Staff to document in the child's health record when offered advice following re-hydration. The above improvements are to be discussed at the teams' Huddle/team meeting to re-engage staff in the process of documenting in the child's health record so there is clear evidence that the process is being adhered to.
Re-audit of School Immunisation	School Immunisation team	100% compliance was met in 11/16 questions.	Standard Operational Guidelines have been updated including review and update of monitoring forms.

Service Cold Chain process			All staff have been notified of audit results and the requirement to improve in some areas Further audit proposed for 2018.
An audit to ensure support provided by the Infant Feeding Team to infants with Tongue Tie is compliant against NICE Guidance	Infant Feeding Team	39% of services users who had division, could be perceived as having a positive influence on breast feeding or continuation of breast feeding, as per NICE suggestion.	All referrals are being actioned on date of referral. Any referrals that require amendments i.e. incomplete referral forms are being reviewed once returned on the amended forms date, and not the original referral dates.
Idiopathic Constipation in Children and Young People	Community Children's Teams East and West	Overall compliance across the 18 standards was 89%. The results were very well received and reflected the high level of work the service operates to.	To include as a static item on the CCN's weekly Patient Update Session to discuss patients who have been identified with 'Red Flags'. Update the Initial assessment paperwork with prompts / questions to help increase compliance. Update the patient information leaflet.

(Source: Universal PIR P35 Audits)

Competent staff

The service mostly made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Clinical staff did not always have appropriate specialist training in relation to their roles. For example, palliative care staff were not provided with specialist palliative care training. They worked with children in the community who required specialist care. Staff would benefit from having a programme of specialist training and/or supervision in place to support them in their professional roles and provide good quality care to children receiving palliative care.

Other services we looked at were proud of ensuring their competency through specialist training and supervision. For example, the physiotherapy team told us they were proud of their supervision programme for all team members. The programme had been adopted by other NHS trusts. Staff were also supported in obtaining role specific training and development to continue to build on their competencies to provide good quality to care to those used the service.

The trust employed a specialist practitioner team that included clinical practice educators. They provided education, supervision and support to nursing disciplines in the service. They offered support and training packages for newly and non-qualified staff. This team supported the transfer of fields project. This project supported dual qualification so that staff could competently care for children and young people across the full age range of the service. For example, a dual qualified health visitor and school nurse could cover a wider range of duties. The team also has community development staff who support partnership working in communities.

The service offered a range of specialist interventions and staff were supported in being competent in their role. For example, a community breast feeding team who offered a tongue tie service in the community. Staff at all levels were trained, for example, a nursery nurse completed a degree course. Senior staff observed and monitored competencies to ensure staff were skilled to carry out their role. One staff member was completing a doctorate in public health. Nursing staff at the 0-19 service were supported to and the trust paid them to complete a degree to be a school nurse.

Staff were supported to receive management supervision every 6-8 weeks which was recorded. Clinical supervision varied. Staff were offered one to one and group/peer supervision. All staff received safeguarding supervision with a named nurse. Staff received annual appraisals to support them in identifying outcomes and future goals.

To further support staff development, professionals from other agencies and directorates would attend team meetings or special training day to provide training. For example, emotional health management training.

Staff were involved in their own discipline's networks. For example, each professional group was part of a local network. These networks were attended by team leaders and professional leads. For example, the institute of health visiting and professional groups such as Royal College of Speech and Language Therapists. School nurses were part of the school nurses' network. People who attended the networks worked collaboratively and learned from others within their profession.

A new supervision policy for Midlands Partnership Trust was ratified by Trust Board in March 2019.Staff within this service had been using the policy of Staffordshire and Stoke on Trent Partnership NHS Trust up until the time of our inspection. The type of supervision accessed was guided by the role, professional group and personal needs of individual staff and agreed with their manager. Staff told us the total number of clinical, professional and managerial supervision sessions accessed may exceed once per month.

Whilst the trust used electronic staff record for the monitoring of appraisal and training, they relied on a local system of monitoring the delivery of supervision compliance. Each team manager held a record of access to supervision and was responsible for overseeing compliance with the supervision policy.

This was offered in range of formats including; individual, group, peer, team and multi-disciplinary meetings and caseload supervision. Whilst it may not be described as supervision some services (such as district nursing) used clinical handover to offer continuous clinical and caseload supervision where advice on managing cases was offered as a group. There were a range of purpose specific supervisions delivered to targeted groups of professionals and services such as child protection supervision.

The trust was in the process of aligning the existing supervision policies from the two legacy organisations and an updated policy was being put in place by early 2019, which represented the new trust.

(Source: CHS PIR CHS4 Clin Supervision)

Appraisal rates

From April 2018 to November 2018, 75% of staff within the community health services for children, young people and families core service had received an appraisal compared to the trust target of 90%.

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
NHS infrastructure support	10	10	100%	90%	Yes
Support to ST&T staff	23	23	100%	90%	Yes
Qualified Allied Health Professionals (Qualified AHPs)	95	102	93%	90%	Yes
Support to doctors and nursing staff	145	187	78%	90%	No
Qualified Healthcare Scientists	3	4	75%	90%	No
Qualified nursing & health visiting staff (Qualified nurses)	173	268	65%	90%	No

Medical & Dental staff - Hospital	4	9	44%	90%	No
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	0	1	0%	90%	No
All staff	**453**	**604**	**75%**		

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff worked collaboratively with other agencies and disciplines. They completed joint assessments to plan and deliver people's care and treatment. For example, the hospital at home team worked closely with hospitals and GP's to reduce hospital admissions by providing treatment in the home. We saw that this was an effective service where families were supported to live well in their own homes and the community.

Staff attended regular meetings to ensure joint working to support people in the community. For example, community development workers focused on public health initiatives working alongside other agencies in the community. Staff told us there were lots of good outreach services into schools which worked alongside teachers and carers. The safeguarding hub staff worked alongside local authority staff and criminal justice staff. For example, there were close links with the police to ensure relevant information was shared, to provide safe joint support for those involved in services.

When children and young people were discharged from a service, staff attended handovers or shared discharge information at joint meetings by email or letter. This meant that the right information was shared with GP's and other relevant professionals to ensure the child and family fully understood what was happening and any next steps.

Health promotion

Health promotion was managed by the community development staff within the 0-19 service. The service employed a public health advisor. They delivered health promotion advice to schools around emotional wellbeing and self-esteem. They were mindful of cultural and health equality issues. They provided healthy eating information at events. Staff also delivered health promotion around bed wetting, height and weight and hearing tests. Staff gave us lots of examples of where they worked to promote healthy living within local authorities. For example, a service called active families, commissioned by the local authority to reduce obesity.

Staff delivered health promotion advice as part of their daily roles. Staff actively promoted the importance of flu vaccination. The trust was part of a health literacy health area. There were health literacy champions who contributed to the health literacy community partnership which helped families and people generally to access information. Some of the initiatives involved redoing leaflets and flyers to make them parent and children friendly. We saw evidence of health promotion literature.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Overall, staff told us they understood that young people could make independent decision and where appropriate, involve their families or carers in decisions about consent. Staff asked parents for consent to share information with other health professionals or agencies. For example, staff completed consent forms for referrals to social services We saw this recorded in electronic records.

Staff compliance with documenting consent to treatment was varied. We did not always see consent to treatment recorded on the electronic patient record system, however we found evidence of consent obtained within patient documentation. On one occasion we saw a nurse obtain consent from a parent rather than acknowledge the young person could have consented directly. When asked, the staff member did not appear to understand Gillick Competency. This was when a child or young person was assessed as capable of consenting to treatment without parental consent.

The trust set a target of 90% for completion of Mental Capacity Act Level 2 training.

From 1 April 2018 to 30 November 2018 the trust reported that Mental Capacity Act Level 2 training had been completed by 95% of staff within community health services for children, young people and families.

Is this service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We observed compassionate interactions with people who used the service and the way staff spoke with us about their role and their contribution to the wellbeing of others.

Staff across services had achieved the 6C's award. The award was given to staff who demonstrated the values and behaviour that reinforced Compassion in Practice. Each of the 6C's – compassion, care, competence, communication, courage and commitment carried equal weight.

Staff provided us with examples of when people who used services and those close to them needed additional support. For example, to help them understand and be involved in their care and treatment and enable them to access it without barriers. This included language interpreters, sign language interpreters, specialist advice or advocates.

Emotional support

Staff provided emotional support to patients to minimise their distress. Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. For example, people could access a psychologist to help them manage difficult emotions. There were volunteers and voluntary organisations available to help support loved ones and offer some respite. Staff could signpost to these agencies to for ongoing emotional support, for example bereavement services.

Staff focused on empowering people to manage their own health, care and wellbeing and to maximise their independence. This was demonstrated in the services provided, for example, hospital at home where people were supported to maintain their independence. This was also demonstrated by staff working in the 0-19 service hub. We saw lots of interaction with people who required support to ensure their emotional wellbeing. For example, new mothers who wanted someone to talk to when they were struggling. Staff were trained to recognise and assess people's emotional needs.

Staff in the palliative care team supported parents and others close to the child who has received bad news. People were provided with bereavement or counselling services information. The children's mental health service was accessible when there were specific mental health needs. This meant there were a range of resources available to people to support their wellbeing.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. This was demonstrated in the care planning records, where people who were involved in care could contribute to improving outcomes.

Is this service responsive?

Planning and delivering services which meet people's needs

The trust planned and provided services in a way that met the needs of local people. The leadership team worked with commissioners, other providers and relevant stakeholders in planning services. Information about the needs of the local population used to inform how services are planned and delivered. Engagement and involvement of children and young people and their families was documented in consultation paperwork to help with the design and running of the services. When contracts were recommissioned, and budgets were cut further, the trust renegotiated services. For example, negotiated with commissioners that midwives would refer to the hub if there were families assessed as needing health visitor input.

Health professionals worked collaboratively to plan and deliver services. Community paediatric services, child and adolescent mental health services (CAMHS), GPs, health visitors, practice nurses and midwives and social care providers/social services / education providers met regularly to meet the needs of children and young people in the area. Staff told us that young people could access education in schools and access to contraception and sexual health clinics. Staff were concerned that they were unable to provide this service widely and that it might impact on a rise of sexual health issues including pregnancy because sexual health cutbacks.

Meeting the needs of people in vulnerable circumstances

The trust supported a wide demographic. Staff completed equality and diversity training to understand the diverse populations they served. In some areas there were high migrant populations. There were high volumes of eastern Europeans, Asian and Polish people in the area. Staff told us there was an increase in the number of Italian and Turkish people. One school was reported to have 44 languages spoken. Staff could access language line for interpreting support. Staff could request health information in a limited number of other languages.

People with mobility issues could access and use services on an equal basis to others. People could access downstairs waiting rooms and there were lifts to access other floors. Entrances had disability access and a ramp leading in. This made the premises accessible for mothers using pushchairs. There were disabled parking spots. Adjustments were made to accommodate people's individual circumstances, for example people could be seen at other locations if they requested it.

Staff understood children and young people accessed services using new technology. Those who used services were given access to further information or ask questions about their care and treatment using a variety of methods. For example, children who may not want to have a face to face conversation were provided with a confidential helpline text service. People could access information by following services on social media.

Access to the right care at the right time

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to assess, treat and discharge patients were in line with good practice.

People had timely access to initial assessment, diagnosis and urgent treatment. As far as possible, people accessed care and treatment at a time to suit them. Care and treatment were cancelled or delayed only when necessary. Cancellations were explained to people and were supported to access care and treatment again as soon as possible. Services ran on time and people were kept informed about any disruption.

People could access a central contact system; this included families, schools and other professionals. They had a system to review how long people had to wait and adapted their services to avoid delays. Staff gave us examples of when they have helped people in crisis, for example people with mental health needs. Staff told us, when necessary, they rang 999 and involved crisis teams to help as soon as possible.

Healthcare professionals assessing or treating children with unscheduled care needs, in any setting, had access to the child's shared electronic healthcare record. Services worked together with local primary care and community services to develop care pathways for common acute conditions.

There were documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care services.

The largest ethnic minority group within the trust catchment area was Asian / Asian British with 12.3% of the population.

	Ethnic minority group	**Percentage of catchment population**
First largest	Asian/Asian British	12.30%
Second largest	White Other	8.00%
Third largest	Mix heritage	4.30%
Fourth largest	Black/Black British	2.70%

(Source: Universal PIR P48 Accessibility)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Complaints and compliments were encouraged and there was a system to monitor and review them. There were various methods to make complaints or raise concerns. Staff told us they provided people with patient advice and liaison service (PALS) leaflets. We saw complaints posters and leaflets on display in all appropriate areas. There was a specially designed leaflet for children who were young people to make it easy for them to understand. Staff would try to resolve local complaints informally in the first instance. There was a process for people to raise a formal complaint. Staff were able to talk people through the process. The information was used to change and improve the service.

Complaints were not always investigated and resolved promptly. From 1 October 2017 to 30 September 2018 there were four complaints about community health services for children, young people and families; one of which had since been withdrawn. The core service took an average of 59 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 35 days (SSOTP) or 25 days (SSSFT).

However, the overall number of complaints was low, and staff told us they tried to resolve any concerns directly, so they did not become cause for formal complaint.

A summary of complaints within community health services for children, young people and families by subject and site is below:

Subject	**Number of complaints**
Values and Behaviours (Staff)	2
Access to Treatment or Drugs	1
Clinical Treatment	1
Total	**4**

From 1 October 2017 to 30 September 2018 the trust received 10,971 compliments. Of these 1,300 related to community health services for children, young people and families, which accounted for 12% of all compliments received by the trust. The health visitors, physiotherapy and speech and language staff received high levels of compliments. This was reflected in the positive messages and thank you cards from parents and children we saw in all the community hubs.

Team	Number of compliments
Health Visiting	456
Physiotherapy	149
Speech and Language	146
Our Health 5-19	134
Community Breastfeeding	98
Tiny Talk	65
School Age Immunisation	58
Dietetics	58
Breastfeeding Support	36
Community Nursing	32
Occupational Therapy	20
Diabetes	13
Youth Diversion	11
Community Children's Nursing West	7
Paediatric Community West	5
Paediatric Community East	4
Enuresis	4
Community Children's Nursing East	4

(Source: Universal PIR P53 Compliments)

Is this 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.

Leaders across the service were employed based on their skills, knowledge, experience and integrity.

There were three neighbourhood managers covering three geographical areas and team leaders who oversaw some services. However, Community Paediatrics and CCN East and West had service managers and were not led by the neighbourhood managers.

Leaders demonstrated an understanding of the challenges to good quality care and the actions needed address them. For example, through appraisal, all team leaders were tasked with achieving 6C's challenge awards.

Leaders used a case management system to help staff effectively and safely manage their caseloads and roles. Overall, a theme from staff was that of feeling supported, appreciated and that leaders were approachable. We noted that some staff in the south of the area expressed less satisfaction with their leadership and their ability to support them. For example, staff reported feeling less prepared for planned changes to their local services.

Senior leaders within the trust had been visible throughout the process of merging the two trusts and staff transferring into Midlands Partnership Trust were aware of their new chief executive and managing director.

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 knew and understood the vision and a set of values, with quality and safety the top priority. The strategy had originally been two strategies, which had been brought together to achieve priorities and deliver good quality care. Leaders told us that the senior leadership team involved staff in developing the strategy.

Staff we spoke with told us they understood the revised vision and values. They felt that communication and values were shared well with staff and there was a drive to unify whole of the trust. Staff told us they put the child and family at the centre of what they did and services that reflect those values. For example, empowering people to improve care and wellbeing and the importance of partnership working.

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 told us they felt supported and valued by managers and the trust. They felt included in processes of change and improvements. They felt confident that they could speak up without blame and would be heard. Staff knew the trust had two 'freedom to speak up guardians' and felt confident that they could speak with them. Staff knew and understood the values of the trust and worked together for the benefit of those who used the service.

There was a commitment to continuous learning and improvement because of incidents, audits, training and development opportunities.

Governance

The trust used a systematic approach to continually be improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The leadership team attended several governance meetings or meetings with governance as a standard agenda item. There were locality meetings that fed into the neighbourhood meetings on a monthly basis. In addition to this CCN teams and Community Paediatrics attended a monthly operational meeting. A monthly children's committee was attended by the children's head of strategic safeguarding. In addition, there was a monthly children's integrated partnership board and a clinical care directorate – children's quality governance subcommittee. Senior governance meetings were attended by head of finance, information governance staff, and key corporate players, including the non-executive director. The content of these meetings was fed in to local quality meetings and groups. We saw minutes from the meetings which documented actions and outcomes.

The leadership team, in collaboration with staff, identified issues to flag up as a governance issue. The leadership team carried out a service delivery plan every month to feed back to neighbourhood managers. This included sickness, performance, for example an example of a nurse off sick which meant they could not deliver what the nurse delivered. The leadership team managed service delivery risks associated with the absence. Staff had to access to and contributed to a risk register. There were several issues identified at inspection that were on the risk register. For example, access to appropriate wash facilities. There were associated plans to mitigate against those risks.

There were several local initiatives that were overseen as part of the governance process. For example, paediatric physiotherapy services had introduced a new intervention for children with cerebral palsy. There was a pathway involving intensive community input post-surgery which had been excluded from the trust provision. This saw a large increase in the number of children on the pathway that put a strain on team capacity. Commissioners were aware and waiting to sign off the service provision. This was having an impact on overall paediatric physiotherapy capacity. Leaders kept oversight and worked with commissioners and oversee the work in process.

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.

There was an effective governance framework to support the delivery of the strategy and good quality care. Staff were clear about their roles and understood what they are accountable for. For example, health visitors were clear if they had not completed the transfer of fields training. All staff we spoke acknowledged their roles and limitations.

The trust and leadership team worked closely with commissioners and partner agencies to agree and manage joint working arrangements. For example, local authority staff working alongside trust staff to provide better joined up care.

The service contributed to the overall governance framework and management systems, which were regularly reviewed and improved. We saw this evidenced in our discussions with leaders, other staff and documented in meeting minutes and documentation.

There were effective systems in place to monitor compliance with key performance indicators. There was data gathering, recording and monitoring system that was used to manage quality and performance.

There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. We saw this recorded and demonstrated in practice.

All services had a business continuity plan. For example, plans for winter pressures. Nursing staff were aware that they would have to be flexible during these periods.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had access to up to date technology to record, store and manipulate information. Patient information, trust updates, policies and procedures could be accessed through the trust's electronic record system and intranet.

Patient paper records were in the process of being migrated on to the computer system. Where appropriate patient information could be accessed using partner agency systems. For example, some GP care record systems. All information was secured using strict safeguards. Access to patient information could be monitored using the electronic system in the form of an audit trail.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Staff were invited to engage with the development of the service. There was month of roadshows. There were staff workshops, executive drop ins and briefings for managers. Everyone had an opportunity to be included. Staff told us there had been a lot of change of migrating systems on to new systems. Staff continued to receive a monthly newsletter, weekly bulletin, pings on computer with updates.

Social media and technological advances were used to engage with key stakeholders. For example, social media was used to share information and engage with communities to learn and grow as a service. Data was gathered by staff to monitor the level of engagement. For example, one social media account had 60 followers and 30 following which was an increase compared to

numbers last quarter. Another social media account was used to promote messages, for example, advantages of breast feeding. The social media account had an increase in followers and likes. This data was gathered and translated to a narrative style report on a quarterly basis.

Service user feedback was service specific. For example, the children's speech and language therapy staff provided service user and carer experience feedback tools. The format was easy to use, tick box and pictorial. This information was used to inform quality of service delivery and to help make improvements. Staff engaged regularly with schools and the community to share information about changes in services. One school nurse who was a professional lead had been on the radio to talk about child health.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There were examples of where financial pressures had impacted on staff and care. For example, the 0-19 service had been reconfigured. The service had less funding and had to be streamlined to ensure they continued to offer an effective and safe service. They had introduced a new model of working that meant staff were in position to work efficiently to respond to people who wanted to use the service. The service was continually monitored using technology, logging data and using the information to inform where to target resources and how to improve their service. Staff we spoke with in the North of the service were enthusiastic and proud of how well they managed the service and how much more efficient and effective they were in responding to the people who used the service.

Improvements to quality and innovation was recognised and rewarded. There were examples of this throughout the service. For example, there were cardiopulmonary resuscitation (CPR), an emergency procedure to restore breathing. Staff were looking at a mental health project to align with tier 1 child and adolescent mental health service in schools. There were four clinics a week for constipation and bed wetting which were nominated for staff awards. Staff in one service were given a national award for the creation of a risk matrix and which has now been shared with three other NHS trusts.

NHS Trusts participate in some accreditation schemes whereby the services they provided were reviewed and decisions made whether to award the service with an accreditation. A service will be accredited if they were able to demonstrate that they met a certain standard of best practice in the given area. An accreditation usually carried an end date (or review date) whereby the service would be re-assessed to continue to be accredited.

The table below shows which services within community health services for children, young people and families had been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	**Service/Team accredited**
UNICEF Baby Friendly accreditation for infant feeding and early parenting	Health Visiting service in 2015, reaccredited October 2017

Community health inpatient services

Facts and data about this service

At the time of our inspection the trust provided adult community inpatient services at the Haywood Hospital. One ward, Brighton House was opened within Haywood Hospital to respond to winter

pressures and closed again by the time of our inspection. For this reason, it appears in some of the data for the reporting period we set for the trust.

Information about the sites and teams, which offer services for inpatients at this trust, is shown below:

Location / site name	Team/ward/satellite name	Number of inpatient beds
Haywood Hospital	Haywood Chatterley Ward	25 beds
Haywood Hospital	Haywood Grange Ward	32 beds
Haywood Hospital	Haywood Jackfield Ward	20 beds
Haywood Hospital	Haywood Broadfield Ward	23 beds
Haywood Hospital	Haywood Sneyd Ward	20 beds

(Source: Universal PIR P2 Sites amended)

Broadfield Ward

This ward has 23 beds and provides care for adult patients requiring neurological rehabilitation. Patients present with a variety of neurological diagnoses including stroke, Multiple Sclerosis, traumatic brain injury, brain tumours and spinal problems.

Chatterley Ward

This ward has 25 beds; 20 intermediate care/ rehabilitation and complex assessment beds and 5 palliative care beds.

Grange Ward

Grange Ward has 32 beds and takes a combination of step down and step up patients. The step up patients will come from their place of residence or directly from the emergency portals.

Jackfield Ward

This ward has 20 rehabilitation beds; accommodating patients with complex assessment and rehabilitation needs.

Sneyd Ward: Stroke Rehabilitation Unit

This ward has 20 beds and provides specialist and co-ordinated rehabilitation to adults following a stroke and is part of a wider stroke service that includes an acute stroke unit based at the University Hospital of North Midlands and the Community Stroke Team at the Haywood Hospital.

The rehabilitation is provided by a range of specialist health professionals which includes medical, nursing, occupational therapy, physiotherapy, speech and language therapy and dieticians.

From October 2017enter a date and September 2019enter a date, no patients (0%) attending community inpatient services within the last 12 months were identified as being child aged 17 years or under.

(Source: Universal PIR P9 Children)

Is this service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and most staff completed it

The trust set a target of 90% for completion of mandatory training. In community inpatient services the 90% target was met for six of the 17 mandatory training modules for which staff were eligible.

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)

Corporate Induction	226	235	96%	90%	Yes
Local Induction	226	235	96%	90%	Yes
Mental Capacity Act Level 2	187	197	95%	90%	Yes
Prevent Awareness	218	235	93%	90%	Yes
Equality and Diversity	215	235	91%	90%	Yes
Safeguarding Adults (Level 1)	210	234	90%	90%	Yes
Safeguarding Children (Level 2)	209	234	89%	90%	No
Health and Safety (Slips, Trips and Falls)	206	235	88%	90%	No
Manual Handling - Object	15	17	88%	90%	No
Conflict Resolution	192	220	87%	90%	No
Infection Prevention (Level 1)	183	214	86%	90%	No
Fire Safety - 1 Year	201	235	86%	90%	No
Adult Basic Life Support	173	218	79%	90%	No
Information Governance	186	235	79%	90%	No
Fire Safety Instruction & Evacuation - Level 3	130	214	61%	90%	No
Manual Handling - People	131	217	60%	90%	No
DMI - Foundation Violence & Aggression	0	1	0%	90%	No
Total	**2908**	**3411**	**85%**	**90%**	

A breakdown of compliance for mandatory training courses from 1 April 2018 to 30 November 2018 for qualified nursing staff in community inpatient services is shown below. In community inpatient services the 90% target was met for nine of the 16 mandatory training modules for which qualified nursing staff were eligible.

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Corporate Induction	88	91	97%	90%	Yes
Local Induction	88	91	97%	90%	Yes
Mental Capacity Act Level 2	84	90	93%	90%	Yes
Equality and Diversity	84	91	92%	90%	Yes
Prevent Awareness	84	91	92%	90%	Yes
Safeguarding Adults (Level 1)	84	91	92%	90%	Yes
Safeguarding Children (Level 2)	83	91	91%	90%	Yes
Health and Safety (Slips, Trips and Falls)	82	91	90%	90%	Yes
Fire Safety - 1 Year	82	91	90%	90%	Yes
Conflict Resolution	78	91	86%	90%	No
Infection Prevention (Level 1)	76	90	84%	90%	No
Information Governance	73	91	80%	90%	No
Adult Basic Life Support	71	91	78%	90%	No
Fire Safety Instruction & Evacuation - Level 3	58	90	64%	90%	No
Manual Handling - People	57	91	63%	90%	No
DMI - Foundation Violence & Aggression	0	1	0%	90%	No
Total	**1172**	**1363**	**86%**	**90%**	

A breakdown of compliance for mandatory training courses from 1 April 2018 to 30 November 2018 is not available for medical staff in inpatient services as they do not have any permanent medical staff. There were seven agency medical staff working at Haywood hospital between October 2017 and November 2018. Mandatory training compliance is a pre-requisite for employment as a locum and was checked on employmentmedical staff.

From the data we can see fire safety instruction and evacuation level 3 and manual handling-people were well below the trust target at 64% and 63% compliance respectively at that time.

We asked the trust to provide us with more recent data, for the period up to end of February 2019. Those figures showed the position as much the same rate of compliance across the wards of between 84% and 89%.

Registered nurses (the largest staff group) were within a range of 68% to 81% across the five wards with most wards in the low to middle 70%-80% band. These figures are below the trust target of 90%.

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.

The trust set a target of 90% for completion of safeguarding training.

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion (%)	Trust Target	Target met (Yes/No)
Safeguarding Adults (Level 2)	210	234	90%	90%	Yes
Safeguarding Children (Level 2)	209	234	89%	90%	No
Total	**419**	**468**	**90%**	**90%**	

A breakdown of compliance for safeguarding training courses from 1 April 2018 to 30 November 2018 for qualified nursing staff in community inpatient services is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion (%)	Trust Target	Target met (Yes/No)
Safeguarding Adults (Level 2)	84	91	92%	90%	Yes
Safeguarding Children (Level 2)	83	91	91%	90%	Yes
Total	**167**	**182**	**92%**	**90%**	

At ward level all wards met the trusts compliance target of 90% for applicable safeguarding training.

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 at risk from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult at risk, 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.

Community inpatient services made four safeguarding referrals between 1 October 2017 and 30 September 2018, all of which concerned adults.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

We spoke with staff across a range of roles in the hospital. They all told us how to respond if they had concerns about the safety of a patient or a visiting child. Some were able to provide us with

recent examples of how they had acted and the positive support they received from local managers to follow trust policy and guidelines.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

For example, we noted each area of the hospital and the six wards we visited was visibly clean, clutter free and easily cleaned. All staff we saw followed the trust's policy of not wearing long sleeves or ties. We saw good stocks of personal protective equipment available to staff and we saw staff cleansing their hands frequently.

However, for one patient who had a query infectious disease, although in a single room with a notice on the door to consult staff before entering, visiting family members told us they had not been given the directive to wear apron and gloves as we had. We struggled to find a nearby clinical waste bin to dispose of these on our way out of the room.

Environment and equipment

The service had suitable premises and equipment and looked after them well. For example, we saw across all six wards we visited resuscitation equipment was available and checked daily. Waste was managed safely with clear labelling of bins. Equipment was fit for purpose and ward staff confirmed there were effective systems in place for maintenance and repair.

Toilets and bathrooms were furnished with fittings suitable for use of people with disabilities, for example high rise toilets.

Ward managers regularly audited the ward environment as required by report to the matron's dashboard.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff in most wards kept clear records and asked for support when necessary.

We looked at the records of fourteen patients across the six wards and found priority risk assessments were undertaken on admission. There was a system in place within patient's records to signpost staff to complete other risk assessments at certain intervals after admission and we saw these were completed. Management plans were in place for significant risks, for example falls, hydration, bed rails. These plans were reviewed regularly. However, the layout of these records in patient files varied across wards. In one ward for example, a new staff member, bank or agency worker would struggle to easily find the plans of care associated with the risk assessments for a patient.

We observed staff managed risks positively with patients. For example, this included when a patient living with dementia was really challenging the service and constantly on the move around the ward.

The hospital had no medical cover overnight. It relied on out of hours services. We asked staff how they responded to a deteriorating patient. They were clear about the trust policy of effective application of the early warning assessment tool (MEWS) to enable deterioration to be identified at the earliest possible stage. This was then supported by the 999 emergency services if necessary. One patient gave us an example of this in action; they confirmed it had happened without hesitation when the patient in the next bed got into difficulty one night at the time of our visits.

However, we noted from data provided by the trust that up to end of February 2019 compliance for annual update of adult basic life support mandatory staff training was below the trust target of 90% across all wards. Compliance rates ranged between 72% and 78%.

Staffing

Although the service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment, nursing and support staffing levels were under constant pressure. Bank and agency staff filled vacancies.

Staff fill rates compare the proportion of **planned** hours worked by staff (Nursing, Midwifery and Care Staff) to **actual** hours worked by staff (day and night). All trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means; In January 70% of the planned working hours for daytime nursing staff were 'filled'.

Details of staff fill rates within community inpatient services for registered nurses and care staff between September 2018enter a date and November 2018enter a date for each site published on their website by the trust are below:

For community inpatient services, there is information for five wards. These are:

- Broadfield
- Chatterley
- Grange
- Jackfield
- Sneyd

Key:

> 125%	< 90%

	September 2018				October 2018				November 2018			
Ward	**Day RN**	**Day CS**	**Night RN**	**Night CS**	**Day RN**	**Day CS**	**Night RN**	**Night CS**	**Day RN**	**Day CS**	**Night RN**	**Night CS**
Broadfield	86.3	160.4	103.2	149.2	98.8	152.1	99.1	146.0	93.6	144.5	97.7	144.7
Chatterley	96.7	102.4	98.3	100.2	95.7	108.2	100.0	100.2	107.6	104.1	99.8	100.0
Grange	91.6	93.1	110.0	90.1	99.4	106.5	101.5	142.5	100.1	106.7	103.7	168.3
Jackfield	119.8	134.3	100.0	137.7	117.6	112.1	100.0	129.9	118.4	102.4	100.0	99.9
Sneyd	103.7	121.6	99.7	133.3	103.5	113.1	98.4	154.8	101.3	111.5	101.6	144.1

The above table shows one red risk ward event in September 2018 for registered nurses. This picture improved over the three month period although Broadfield ward remained under pressure each month. The trust was managing this through the risk register.

Year 1 (31 March 2018) section:

Details of staffing levels within community inpatient services by staff group as at 31 March 2018 are shown below.

Community inpatient services total

Staff group	Planned staff WTE	Actual Staff WTE	Staffing rate (%)
Support to doctors and nursing staff	92.4	120.7	131%
NHS infrastructure support	3.4	3.6	106%
Qualified nursing & health visiting staff (Qualified nurses)	86.2	87.3	101%
Qualified Allied Health Professionals (Qualified AHPs)	5.0	1.8	36%
Support to ST&T staff	3.0	0.6	20%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	1.0	0.0	0%
Grand Total	**191.0**	**214.1**	**112%**

Year 2 (30 September 2018) section:

Details of staffing levels within community inpatient services by staff group as at 30 September 2018 are below.

Community inpatient services total

Staff group	Planned staff WTE	Actual Staff WTE	Staffing rate (%)
Support to doctors and nursing staff	132.8	116.7	88%
Qualified nursing & health visiting staff (Qualified nurses)	111.3	86.6	78%
NHS infrastructure support	4.9	3.5	72%
Qualified Allied Health Professionals (Qualified AHPs)	3.0	1.8	60%
Support to ST&T staff	3.4	1.0	29%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	1.0	0.0	0%
Grand Total	**256.3**	**209.6**	**82%**

Data in the tables above shows changes in planned staff WTE across the two time sections with a decrease in year 2 in qualified nursing staff, allied health professionals and support workers. These changes are likely to be accounted for by the reconfiguration of inpatient services and reduction from five locations to just one. The overall percentage staffing rate dropped from surplus to 82% of the planned number across the two periods. The tables below show vacancy levels were high for nursing and support staff. The hospital manager told us this was managed daily through using bank and agency staff and the situation was also under regular review through the risk register.

We noted during our visits to each ward that there were enough staff on duty to meet the needs of the patients. Patients and relatives, we spoke with told us they received the attention they needed from staff when they needed it.

The trust set a target of between 8% and 12% for vacancy rate. From October 2017enter a date to September 2018enter a date, the trust reported an overall vacancy rate of 18% in community inpatient services. This did not meet the trust's target. Across the trust overall vacancy rates for nursing staff were 22%; for allied health professionals were 40% and there were no medical staff assigned to this core service

A breakdown of vacancy rates by staff group in community inpatient services at trust level and by team/site is below:

Community inpatient services total

Staff group	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	1.0	1.0	100%
Support to ST&T staff	3.4	2.4	71%
Qualified Allied Health Professionals (Qualified AHPs)	3.0	1.2	40%
NHS infrastructure support	4.9	1.4	28%
Qualified nursing & health visiting staff (Qualified nurses)	111.3	24.7	22%
Support to doctors and nursing staff	132.8	16.0	12%
All staff	**256.3**	**46.8**	**18%**

Nursing staff by site

Site name	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Total	**111.3**	**24.7**	**22%**

Allied health professional by site

Site name	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Total	**3.0**	**1.2**	**40%**

We asked the trust for updated figures to end of February 2019. Although still above the trusts target rate, these showed an improved picture of 15%.

The trust set a target of between 10% and 15% for turnover rates. From October 2017enter a date to September 2018enter a date, the trust reported an overall turnover rate of 12% in community inpatient services. This met the trust's target. Across the trust overall turnover rates for nursing staff were 8%; for allied health professionals were 0% and there were no medical staff assigned to this core service

A breakdown of turnover rates by staff group in community inpatient services at trust level and by team/site for the year ending 30 September 2018 is below:

Community inpatient services total

Staff group	Average number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
NHS infrastructure support	3.4	0.8	24%
Support to doctors and nursing staff	109.2	17.1	16%
Qualified nursing & health visiting staff (Qualified nurses)	82.5	6.5	8%
Qualified Allied Health Professionals (Qualified AHPs)	1.6	0.0	0%
Support to ST&T staff	0.5	0.0	0%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	0.0	0.0	N/A
Total	**197.2**	**24.3**	**12%**

Nursing staff by site

Site name	Average number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Total	**82.5**	**6.5**	**8%**

Allied health professionals by site

Site name	Average number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Grand Total	1.6	0.0	0%

We asked the trust to send us more recent data to the end of February 2019. This showed an improvement to 5%. Turnover figures could have been affected by the reconfiguration of inpatient services at the end of 2018.

The trust set a target of 4.8% for sickness rates. From October 2017 to September 2018, the trust reported an overall sickness rate of 5.7% in community inpatient services. This did not meet the trust's target. Across the trust overall sickness rates for nursing staff were 4.6%; for allied health professionals were 0.0% and there were no medical staff assigned to this core service

A breakdown of sickness rates by staff group in community inpatient services at trust level and by team/site between 1 October 2017 and 30 September 2018:

Community inpatient services total

Staff group	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
NHS infrastructure support	1232.1	381.6	31.0%
Support to ST&T staff	199.2	12.0	6.0%
Support to doctors and nursing staff	39613.5	2334.7	5.9%
Qualified nursing & health visiting staff (Qualified nurses)	29964.2	1373.2	4.6%
Qualified Allied Health Professionals (Qualified AHPs)	551.0	0.0	0.0%
Grand Total	**71560.1**	**4101.5**	**5.7%**

Nursing staff by site

Site name	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Total	**29964.2**	**1373.2**	**4.6%**

Allied health professionals by site

Site name	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Grand Total	**551.0**	**0.0**	**0.0%**

We asked the trust to send us more recent data to the end of February 2019. This showed a slight increase to 6%.

Nursing – Bank and Agency Qualified nurses

From October 2017 and September 2018, of the 170,009 total working hours available, 4% were filled by bank staff and 7% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

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

In the same period, less than 1% of available hours were unable to be filled by either bank or agency staff.

Ward / Team	Total hours Available	Bank usage		Agency usage		Not filled	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Haywood Brighton House	12322	583	5%	6749	55%	188	2%
Haywood Broadfield Ward	30645	1817	6%	1421	5%	168	1%
Haywood Chatterley Ward	34814	1096	3%	1738	5%	152	<1%
Haywood Grange Ward	44435	218	0%	402	1%	16	<1%
Haywood Jackfield Ward	14975	1891	13%	964	6%	83	1%
Haywood Sneyd Ward	32817	1830	6%	827	3%	61	<1%
Core service total	**170009**	**7433**	**4%**	**12100**	**7%**	**666**	**<1%**

Nursing - Bank and Agency Non-Qualified nurses

From October 2017enter a date and September 2018enter a date, of the 206875 total working hours available, 10% were filled by bank staff and 15% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

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

In the same period, 1% of available hours were unable to be filled by either bank or agency staff.

Ward / Team	Total hours Available	Bank usage		Agency usage		Not filled	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Haywood Brighton House	15190	2075	14%	6904	45%	261	2%
Haywood Broadfield Ward	45297	8087	18%	10422	23%	537	1%
Haywood Chatterley Ward	47450	2617	6%	4004	8%	536	1%
Haywood Grange Ward	52461	2062	4%	2029	4%	284	1%
Haywood Jackfield Ward	15533	2353	15%	1873	12%	384	2%
Haywood Sneyd Ward	30945	3410	11%	5351	17%	483	2%
Core service total	**206875**	**20602**	**10%**	**30581**	**15%**	**2484**	**1%**

Medical locums

Between October 2017 and September 2018 this core service did not use any medical locum staff to cover sickness, absence or vacancy.

Suspensions and supervisions

During the reporting period from October 2017 to September 2018, community inpatient services reported that there were no cases where staff have been either suspended or placed under supervision.

(Source: Universal PIR P23 Suspension or supervised)

Quality of records

Staff kept detailed records of patients' care and treatment. Most records were clear, up-to-date and easily available to all staff providing care.

The hospital used a paper system for patient's records. There was a multidisciplinary approach to record keeping for example, therapist notes were included in the patients ward record file and they contributed to the patient's progress notes.

However, we noted the layout of patient files varied in their ease of accessibility to staff across the wards. We found many staff names against their sample signatures were illegible. This made this record unfit for purpose as it was not therefore a reliable identity and accountability checker for audit purposes.

Senior ward nurses and local managers told us the record keeping system was a frustration. The Matron confirmed she was working on a plan to improve the paper patients care record system across the hospital. Patient notes were audited every three months.

The trust was appraising options for an electronic patient records system to include Haywood Hospital.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

The hospital had six pharmacists that worked with the wards daily from Monday to Friday. They told us they reconcile patient medication and together with technicians' audit records and stocks and storage conditions. They reported any discrepancies as an 'incident'. They also supported and advised medical staff with a patient's medication review about contra indications. They told us medicines for patients to take home (TTO's) were dispensed on Fridays in order for patients to be discharged over a weekend. On the wards we observed drugs trolleys were kept locked and chained to a wall in the clinical room for security when not in use. Nurses we spoke with confirmed their competency to administer medication is assessed.

Safety performance

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Safety Thermometer data was not available for this trust. However, the trust had systems in place to inform, analyse and monitor safety performance at ward level. For example, each ward recorded its own performance monthly for delivering harm free care. We saw this displayed as a 'safety cross' diagram for staff, patients and visitors to see.

Ward managers collected data for submission to the Matron's safety dashboard. The trust operated a system of peer review of wards carried out by ward managers. The Matron oversaw actions plans ward managers put in place to improve areas where a ward was struggling.

Incident reporting, learning and improvement

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 wider and the service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff in all roles we spoke with were able to describe the incident reporting system and their responsibilities. Most could offer us an example of when they had recently reported an incident. We noted from patient records for example, there was an incident form for pressure sores found on admission. We also heard some examples of how ward staff had been honest and open with patients when something went wrong and offered an apology.

Staff confirmed they received feedback from incidents during regular ward meetings where learning from when something went wrong was passed on.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no never events for community inpatient services.

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in community services for inpatients, which met the reporting criteria, set by NHS England between, October 2017 and September 2018. Of these, the most common type of incident reported was 'Slips / trips / falls' with five.

Incident Type	Number of Incidents
Slips / trips / falls	5
Treatment delay	1
Core Service Total	6

From October 2017 and September 2018, trust staff within community inpatients services reported six serious incidents. Of these, none involved the unexpected death of a patient. The most common types of serious incident were 'slips/trips/falls' with five.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Is this service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We saw from patient records admission assessment was undertaken with nationally accredited tools for skin integrity assessment. Patients' condition was monitored using a national early warning score.

Staff we spoke to confirmed the service followed National Institute of Clinical Excellence (NICE) guidelines for example in treating long term conditions such as stroke. Staff also followed the Royal College of Physicians stroke guidelines to support their stroke rehabilitation service and the British Society of Rehabilitation Medicine for the Rehabilitation Medicine service. We saw from notes each patient was given an estimated date of discharge (EDD) and this was tracked and reviewed daily. In line with NICE guidance the service had a discharge coordinator in post and together with ward manager and therapists they worked daily with the social services and independent social care providers to achieve effective admissions into, and discharge from, the hospital and reduce unnecessary delays. We observed daily meetings within this process.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other preferences. However, a number of the patients we spoke with said the food was not appetising or sufficiently varied.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

For example, we saw from patient's records that pain assessments were in place and nursing staff checked these at least daily. Patients we spoke with confirmed staff were very responsive to their pain and comfort levels. We noted on patients records a visual pain score tool was in place for staff to use for patients who were unable to communicate. The ward assurance dashboard included pain relief management indicators.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The trust had in place as system of patient centered ward assurance audit. We noted from monthly ward assurance summaries dated October 2018 to January 2019 that wards compliance was generally between 90 and 100% across all indicators. On the few occasions where compliance had worsened, for example record that a patient had been weighed on admission, we noted by the following month it had improved. Staff we spoke with confirmed ward managers produced actions plans to achieve these improvements.

The trust has participated in nine clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
A re-audit to measure the compliance of the DNACPR orders on all wards against the Trust's DNACPR Policy (PP-021) from documented evidence within the patient's records (141)	Haywood Hospital wards + Brighton House	All the wards audited reported 100% compliance for the following: · Is the DNACPR form (RED) at the front of the patient records · Are all details/demographics on the form · Is the date of the DNACPR decision completed ·Does the patient have capacity re decision of CPR?	The Resuscitation Officer has requested immediate attention to address the seriousness of the six patients' who had been within the care of the Community Hospital for a period of time which was outside of the 14-day transfer review timeframe. Doctors have been reminded of key DNACPR requirements. Re-audit planned for following quarter.
A re-audit to measure the compliance of the DNACPR orders on all wards against the Trust's DNACPR Policy (PP-021) from documented evidence within the patient's records (Q3)	Community Hospitals	100% of forms audited across the community hospitals had the DNACPR form at the front of the patient records. All wards across the community hospitals were fully compliant in completing the details/demographics on the form.	Resuscitation Officer to meet new medics joining the Trust to inform them of the Trusts' expectation regarding completion of DNACPR forms and associated paperwork. The Resuscitation Officer to carry out spot check audits

			on wards every month in between quarterly audits.
An Audit of the Effectiveness of Nurse to Nurse Handover on the In-patient Wards at Haywood Hospital	Haywood Hospital wards	Full compliance was achieved in all aspects of handover management with the exception of using handover sheets (Chatterley wards). 100% compliance was achieved with inclusion of name, diagnosis, medical history, DNA/ CPR and outstanding actions in handover content.	Audit results shared with ward areas. Each area produced an Action Plan to address areas of non-compliance, monitored by Modern Matron, with re-audit taking place in 18/19. Handover Tool has been standardised to ensure continuity.
Essence of Care Benchmarking Audit - Food and Drink	Haywood Hospital wards	Broadfield) has improved overall compliance in 12 months	Specific actions have been addressed through discussions with Catering/Sodexo. Updated nutritional policy. Review each of the red RAG rated benchmarks and record actions to improve compliance levels with each factor. Project lead re-visiting with wards areas of non-compliance in 6 months.
Falls and Fragility Fracture Audit Programme (FFFAP) National audit of inpatient falls (Spring 2017) 151	North Adult services – Community Hospitals	SSOTP achieved higher than the national average for 15 of the stated benchmarks and matched the	The Delirium standards are included in the Dementia pathway of which has already been cascaded to all ward areas. Dementia Champions to ensure that all elements of the Dementia Pathway are understood & followed by all staff.
P.1. Sentinel Stroke National Audit Programme (SSNAP)	Staffordshire Rehabilitation Team Staffordshire ESD Team	Standards are being met in terms of OT / Physiotherapy therapy input and intensity on the stroke unit due to service developments in implementation of 7 day working. Community Stroke Rehabilitation service maintaining high performance with provision of 6 month reviews.	Continual monitoring of standards / SSNAP data prior to and at reporting period by Stroke Coordinator & Deputy Specialist Service Manager (SSNAP Lead). Training of all staff and engagement within stroke rehabilitation to ensure understanding of SSNAP and consistency of data collated and submitted. Acute Stroke Unit (218 UHNM) provide a clear plan on patients transferring across to stroke rehab unit with swallowing / communication deficits. Recruitment ongoing to stroke rehabilitation especially ESD service to

			support with filling staffing gaps.
P.1. Re-Audit to Assess the Compliance of the Deprivation of Liberty Safeguards within Community Hospitals	Community Hospitals – in-patient wards (Haywood + Leek)	Each ward on both Haywood hospital and Leek Moorlands achieved 100% of: - patient's records had evidence of an urgent/standard application for DoLs. - evidence in the patient's record regarding the application of DoLs. - documented evidence that contact has been made with the patient's representative who is supporting them. - evidence of email exchange and telephone conversations. - incident report completed for the DoLs authorisation	Ensuring an incident report is completed by the hospital and care homes per DoLS referral; Adult Safeguarding Manager is responsible for contacting the wards to highlight any discrepancies between the Incident reporting and the monthly returns. This is reported at Safeguarding Adult Committee (SAC) by the Adult Safeguarding Manager. Adult Safeguarding Manager is to attend Community Hospital Service Committee on a quarterly basis to feedback the audit findings.
Re-Audit to Assess the Compliance of the Deprivation of Liberty Safeguards within Community Hospitals (142) – Q3	Haywood Hospital. 5 wards (Grange, Chatterley, Sneyd, Broadfield)	Each ward at the Haywood hospital achieved 100% regarding evidence of an urgent/standard application for DoLs. The DOLs team were informed in 100% of cases when either discharge or transfer had taken place. Each ward achieved 100% on documenting evidence in the patient's record regarding the application of DoLs. Each ward had documented evidence that contact has been made with the patient's representative who is supporting them with the DoLs in 100% of patient records. 100% of records audited on each ward had an incident report completed	Ensuring an incident report is completed by the hospital or care home for each DoLS referral made; Adult Safeguarding Manager is responsible for contacting the wards to highlight any discrepancies between the incident reporting and the monthly returns. This is reported at Safeguarding Adult Committee (SAC) by the Adult Safeguarding Manager. Adult Safeguarding Manager is to attend Community Hospital Service Committee on a quarterly basis to feedback the audit findings.
Re-audit to measure compliance of DNACPR orders on wards against the Trust's DNACPR Policy (Q1) (141)	All patients with an active DNACPR in Community Hospitals (Haywood Hospital + Brighton House)	The latest results (83% compliance across 23 standards) showed an improvement in compliance of the DNACPR forms on Community Hospital wards against previous audit results (75% Q4, 17/18). All the wards audited reported 100% compliance for the following: • Is the DNACPR form (RED) at the front of the patient records • Does the patient have capacity re decision of CPR • Main clinical problems and reasons why CPR would be inappropriate • Is the form clearly dated, timed and signed (box 6)	The Resuscitation Officer has requested immediate attention to address the four patients' who had been within the care of the Community Hospital for a period of time which was outside of the 14-day transfer review timeframe. Doctors have been reminded of key DNACPR requirements. Trust policy is being updated and a plan being implemented for Advanced Nurse Practitioners to undertake/support the DNACPR role.

		• Name of the doctor who completed the order	A further audit is planned for Q2/3, the results of which will inform the frequency of future audits.

Nursing staff and therapy staff, we spoke with were aware of these audits, the results and their role in action plans in place where improvement was required.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Managers told us that staff received both clinical and managerial supervision and that there were peer support meetings regularly taking place to discuss any patient issues. The service could not provide evidence that monthly staff clinical supervision was being undertaken as per their policy. It meant managers were unable to demonstrate how they had managed the impact of incidents and discussed lessons learnt with individual staff members.

From April 2018 and November 2018, 70% of permanent non-medical staff within the community inpatients core service had received an appraisal compared to the trust target of 90%.

Community inpatients service total

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Qualified Allied Health Professionals (Qualified AHPs)	1	1	100%	90%	Yes
Support to doctors and nursing staff	77	107	72%	90%	No
Qualified nursing & health visiting staff (Qualified nurses)	55	80	69%	90%	No
NHS infrastructure support	1	3	33%	90%	No
Support to ST&T staff	0	1	0%	90%	No
All staff	**134**	**192**	**70%**		

We asked the trust to provide us with more recent data up to the end of February 2019. This showed for qualified nursing staff the range was spread evenly between 40% and 83% across the five wards representing a total average of 64%. This is well below the trust target of 90%.

The service assured us during our visit 'The actual appraisal compliance is significantly better than reported on the dashboard, but ward managers had consistently reported issues with recording them on the electronic record system'.

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We saw joint therapy care plans in place in patient's records. We observed effective handover between shifts of staff on the wards and clear handover records for staff to refer to while caring for a patient during their shift.

We observed ward 'board rounds' where a multidisciplinary group of professionals went through the care plan goals, status and discharge arrangements for each individual patient daily. These demonstrated very effective working relationships between nurses and therapists supporting each patient, flow and discharge coordinators and external agency staff such as social workers to provide safe packages of care and support when a patient was discharged.

Nursing staff worked with GP's who provided the medical care on the wards. There were advanced nurse practitioners (ANP) supporting GP's on the ward.

Staff clearly worked hard at these relationships for the benefit of patients. They were creative in their problem solving where there were any hiccups in a process.

Health promotion

We saw from patient assessment records the trust collected data to support the audit of ill health by risky behaviours alcohol and tobacco. This was reported to the Matron and the data analysed by the clinical audit team to support the NHS England commissioning for quality and innovation (CQUIN) (9a-e). For quarter 3 208/19 the audit had been assigned a 'Green/Amber' level of compliance, based on agreed targets. The trust reported CQUIN 9c 'patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication' at 5% compliance was well below the trust target of 30%. The trust reported this had been entered onto the risk register. Teams had developed local action plans to address individual results, which also is incorporated into a wider CQUIN action plan, managed by the professional lead.

We noted each ward had a series of information boards on the corridor walls with health promotion and specific conditions health care information for patients and visitors to look at. Ward managers told us these were regularly refreshed by ward staff and included monthly themes for example, looking after your liver.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The trust set a target of 90% for completion of Mental Capacity Act Level 2 training.

From 1 April 2018 to 30 November 2018 the trust reported that Mental Capacity Act Level 2 training had been completed by 95% of staff within community inpatient services.

A breakdown of compliance for Mental Capacity Act Level 2 training from 1 April 2018 to 30 November 2018 for nursing and midwifery staff in community inpatient services is shown below:

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Mental Capacity Act Level 2	84	90	93%	90%	Yes

A breakdown of compliance for Mental Capacity Act Level 2 training from 1 April 2018 to 30 November 2018 for allied health professionals in community inpatient services is shown below:

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Mental Capacity Act Level 2	2	2	100%	90%	Yes

All staff we spoke to were aware of their responsibilities within their role and confirmed they had access to mental capacity training on the Trust intranet. Due to the complexity of the patients, Broadfield Ward had additional support from a Neuropsychiatrist on a weekly basis and a Clinical Psychologist.We saw consent forms on patient's files and staff had recorded where patients gave verbal consent within the record of an intervention, for example inserting a cannula.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005**.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

From 1 October 2017 to 30 September 2018 the trust reported that 208 standard Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority, 132 of which were pertinent to community inpatients services. A total of 229 urgent Deprivation of Liberty Safeguard (DoLS) applications were made, 152 of which were pertinent to this core service.

CQC received 129 DoLS related direct notifications from the trust between 1 October 2017 and 30 September 2018.

Number of standard DOLS applications:

Month and year	Number of applications made	Number of applications approved
October 2017	8	7
November 2017	6	6
December 2017	5	4
January 2018	17	9
February 2018	15	6
March 2018	19	12
April 2018	14	11
May 2018	11	6
June 2018	16	12
July 2018	9	3
August 2018	7	3
September 2018	5	4

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to a paper records system that they could all update.

For the patient's whose care we followed we noted their records included up to date contributions from the whole team supporting the patient. This included therapist and GP notes, test results, assessments, care plan goals and comfort round checks.

Is this service caring?

Compassionate care

Staff cared for patients with compassion**.** Feedback from patients confirmed that staff treated them well and with kindness.

All patients and relatives/friends we spoke with told us unreservedly that staff were kind to them. Across all wards we observed staff, including managers taking time to chat with patients. Nursing and therapy staff always spoke with the patient when they were supporting them with tasks or undertaking medical interventions. Staff used patient's names when they addressed them.

Patients who spoke with us said staff treated them sensitively and maintained their privacy and dignity when they supported them with intimate tasks and with eating.

Emotional support

Staff provided emotional support to patients to minimise their distress. We observed impressive example of health care assistants supporting patients whose behaviour was challenging to the service on wards. Nursing staff exercised kind patience and skill to divert patients living with dementia and distressed by confusion. Therapist exercised patience and skill to motivate patients who had lost confidence in their ability to stand and move and use their fine motor skills. Patients and relatives had access to the hospital's Chaplaincy service.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Relatives of patients we spoke with told us staff had involved them in plans of care and consulted them about time line arrangements for discharge. It was clear from observing the ward board rounds that senior nurses knew the details of patient's family/friend support arrangements and primary contacts and the challenges those family members/friends were facing.

Is this service responsive?

Planning and delivering services which meet people's needs

The trust planned and provided services in a way that met the needs of local people. Midlands Partnership NHS Foundation Trust (MPFT) is an integrated organisation that provides physical and mental health, learning disabilities and adult social care services. Most of the trust's services were delivered in Staffordshire, Stoke-on-Trent, Shropshire, Telford & Wrekin. The aim of the integrated approach was to better serve the needs of patients and their families and to reduce confusion about service provision.

The Haywood Hospital adult community impatient services provided; step up beds to receive patients directly from their own homes or usual place of residence or directly from the emergency portals within the local Acute NHS Trust; care for adult patients requiring neurological rehabilitation; intermediate care/ rehabilitation and complex assessment beds and specialist and coordinated rehabilitation to adults following a stroke and is part of a wider stroke service.

The trust was asked to list ward moves for a non-clinical reason during the last 12 months. For example, if a patient must move wards several times because there is no room in the specialty ward they should be on.

From 1 October 2017 to 30 September 2018 there were no ward moves during this period for non-clinical reasons.the sites being inspected:

Haywood Chatterley

Number of ward moves	Number of patients	How many were recorded as "vulnerable"	How many were at end of life	% share of all patients
0	287	0	20	100%

1	0	0	0	0%
2	0	0	0	0%
3	0	0	0	0%
4+	0	0	0	0%
Total	**287**	**0**	**20**	**100%**

Haywood Grange

Number of ward moves	Number of patients	How many were recorded as "vulnerable"	How many were at end of life	% share of all patients
0	426	0	30	100%
1	0	0	0	0%
2	0	0	0	0%
3	0	0	0	0%
4+	0	0	0	0%
Total	**426**	**0**	**30**	**100%**

Haywood Jackfield

Number of ward moves	Number of patients	How many were recorded as "vulnerable"	How many were at end of life	% share of all patients
0	154	0	10	100%
1	0	0	0	0%
2	0	0	0	0%
3	0	0	0	0%
4+	0	0	0	0%
Total	**154**	**0**	**10**	**100%**

Haywood Broadfield

Number of ward moves	Number of patients	How many were recorded as "vulnerable"	How many were at end of life	% share of all patients
0	126	0	0	100%
1	0	0	0	0%
2	0	0	0	0%
3	0	0	0	0%
4+	0	0	0	0%
Total	**126**	**0**	**0**	**100%**

Haywood Sneyd

Number of ward moves	Number of patients	How many were recorded as "vulnerable"	How many were at end of life	% share of all patients
0	167	0	0	100%
1	0	0	0	0%
2	0	0	0	0%
3	0	0	0	0%
4+	0	0	0	0%
Total	**167**	**0**	**0**	**100%**

(Source: Universal PIR P43 Ward moves)

The trust was asked to list ward moves between 10pm and 8am for each core service for the most recent 12 months. From 1 October 2017 to 30 September 2018, the trust reported that there were 52 moves at night for community health inpatient services. The data below shows the number of ward moves by hospital site from 1 October 2017 to 30 September 2018 in community health inpatient services for the sites being inspected:

Haywood Hospital

Ward name	Number of moves
Grange	16
Chatterley	13
Sneyd	7
Brighton House	6
Jackfield	5
Broadfield	2

All moves at night identified in this table relate to step down admissions from the local acute hospital as part of an agreed clinical pathway and not internal transfers within the Haywood hospital.

Same sex accommodation breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. Whilst these are specifically for MH providers the same definitions apply to CHS and Acute providers from a CQC perspective.

The trust reported that between 1 October 2017 to 30 September 2018 there were no same sex accommodation breaches within community inpatient services.

(Source: Universal PIR P44 Moves at night)

Access to the right care at the right time

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were in line with good practice.

The hospital was accessible to patients and visitors with disabilities. The largest ethnic minority group within the trust catchment area is Asian / Asian British with 12.3% of the population.

	Ethnic minority group	Percentage of catchment population
First largest	Asian/Asian British	12.30%
Second largest	White Other	8.00%
Third largest	Mix heritage	4.30%
Fourth largest	Black/Black British	2.70%

(Source: Universal PIR P48 Accessibility)

The trust provided information regarding average bed occupancies from 1 October 2017 to 30 September 2018. Breakdown of bed occupancy levels in September 2018 by ward for community health inpatient services below:

Ward	Bed occupancy (September 2018)	Bed occupancy range (October 2017 to September 2018)
Brighton House	96%	96% - 99%
Chatterley	96%	95% - 100%
Grange	97%	94% - 99%
Sneyd	100%	91% - 100%
Broadfield	91%	85% - 97%
Jackfield	95%	34% - 95%

This shows most wards at most times in this timeframe had average bed occupancy levels above the nationally recommended level of 85%. The trust provided information for average length of stay from 1 October 2017 to 30 September 2018. Breakdown of average length of stay by the ward for community health inpatient services below:

Ward	Average length of stay
Brighton House	22.8 – 56.2
Broadfield	24.6 – 121.0
Chatterley	23.6 – 47.0

Sneyd	23.1 – 51.2
Grange	19.9 – 31.4
Jackfield	13.0 – 42.6

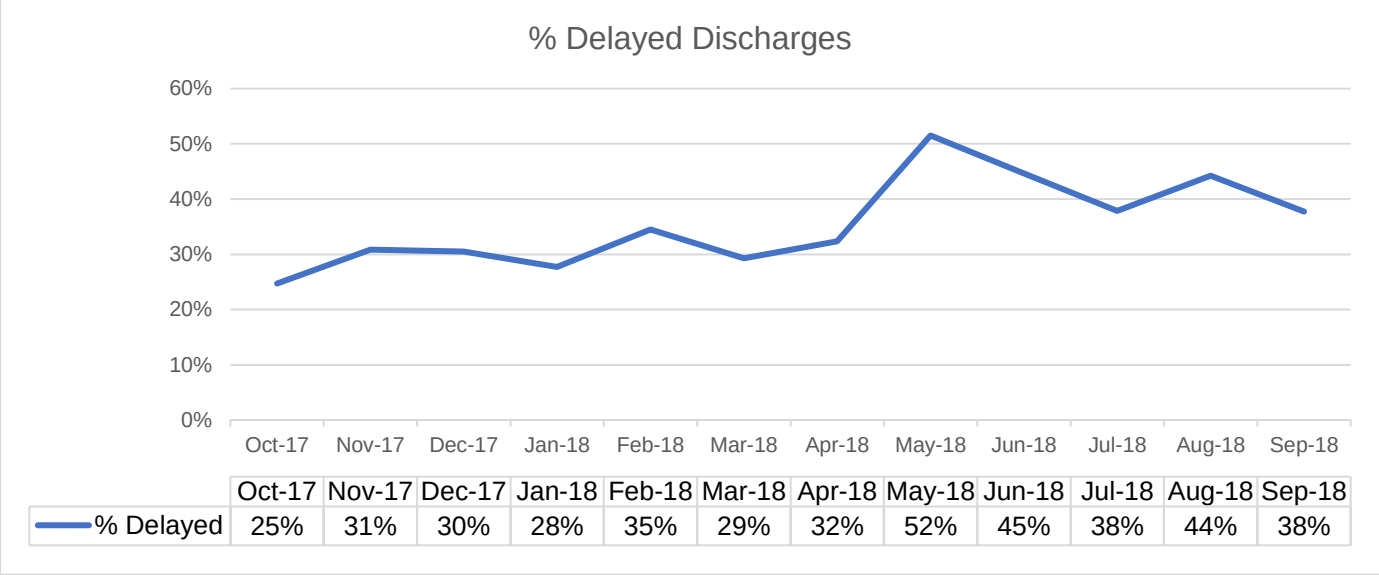
Two national surveys, the NHS Benchmarking Network (NHSBN) Community Hospitals Project and the NAIC found the average length of stay in community hospitals ranged between 11–58 days. The table above shows figures for the Haywood Hospital were mostly in the 2nd quartile of that range. Broadfield Ward was commissioned via NHS England to provide specialist rehabilitation for those patients with complex neurological presentations; acquired brain injuries and for those patients with poly-trauma. Due to their complex presentations, patients may require a long length of rehabilitation of up to six months; this is dependent on their individual need and complexity.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'. The trust met the referral to assessment target in both targets listed. The trust did not provide information about assessment to treatment targets.

Name of in-patient ward or unit	**Service Type**	**Days from referral to initial assessment**		**Days from assessment to treatment**	
		National / Local Target	**Actual (median)**	**National / Local Target**	**Actual (median)**
North Rehabilitation Inpatients	Consultant led service	90 working days (National RTT)	45 work days	N/A	45 work days
North Rehabilitation Inpatients	Consultant led service	90 working days (National RTT)	18 work days	N/A	18 work days

From 1 October 2017 to 30 September 2018, there were 542 delayed discharges in community health inpatient services. This amounts to 36% of the total discharges in this core service.

Delayed discharge trends from October 2017 to September 2018



	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
% Delayed	25%	31%	30%	28%	35%	29%	32%	52%	45%	38%	44%	38%

The chart showed a rising trend in the number of delayed discharges that peaked at 52% in May 2018 reducing to 38% in September 2018. A breakdown of delayed discharges by ward for community health inpatient services is shown below:

Ward	**Total Discharges**	**Total Delayed Discharges**	**% Delayed Discharges**
Brighton House	213	97	46%
Grange	432	184	43%

Jackfield	129	55	43%
Chatterley	300	117	39%
Sneyd	189	57	30%
Scotia*	81	18	22%
Broadfield	145	14	10%
Total	**1489**	**542**	**36%**

*This specialist rheumatology ward closed in July 2018

The service took account of patients' individual needs. We the ward environments were accessible for patients and visitors with physical disabilities and signage around the hospital and the wards was effective. The trust had adapted some ward areas to respond to patients with complex needs. For example, some wards had a dedicated space for diversional therapy and we saw patients being supported by staff to use this resource. Wards had orientation boards to display the time, date and season.

The hospital had a dementia pathway in place and we saw evidence of this within patient's records and conversations with staff and relatives. For example, the trust's 'dementia friendly' charter included the butterfly scheme (each patient or carer has the option to have a discreet butterfly symbol located around their bed space to identify that they have memory impairment). We saw this in place for some patients and relatives we spoke with understood its purpose.

We found one patient was fit for discharge which, was considerably delayed. However, the service was providing no maintenance therapy or activity to keep up their recovery level. This meant they were being treated differently to other patients in a way that could not be justified. We raised this with the Matron and Hospital manager who undertook to review this situation.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From 1 October 2017 to 30 September 2018 there were eight complaints about community inpatient services. The trust took an average of 88 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 35 days (SSOTP) or 25 days (SSSFT).

However, we asked the trust for any action plan in place to bring the timescale closer to its policy target time. They told us there was no action plan. The trust told us they worked in line with the National Health Service Complaints Regulation 2009 (procedure before investigation 13 (7)). Whereby, the investigating officer would meet with the complainant and agree the manner in which the complaint was to be handled, the period within which the investigation was likely to be completed and the associated response likely to be sent to the complainant. This was a mutually agreed timeframe and will vary considerably for each complaint dependent on the complexity of the issues to be investigated and the number of staff required to be interviewed as part of the complaint. If for any reason the complaint cannot be completed within the agreed timeframe the Investigating Officer will liaise with the complainant and negotiate a reasonable extension'.

A summary of complaints within community inpatient services between 1 October 2017 to 30 September 2018 by subject and ward is shown below:

Community inpatient services total

Subject	Number of complaints
Admissions and Discharges (Excluding Delayed Discharge)	4
Patient Care	3
Values and Behaviours (Staff)	1
Total	**8**

Community health inpatient services – Brighton House

Subject	Number of complaints

Patient care	2
Admissions and Discharges (Excluding Delayed Discharge)	1
Total	**3**

Community health inpatient services – Haywood Chatterley

Subject	Number of complaints
Admissions and Discharges (Excluding Delayed Discharge)	1
Values and Behaviours (Staff)	1
Patient care	1
Total	**3**

Community health inpatient services – Haywood Grange

Subject	Number of complaints
Admissions and Discharges (Excluding Delayed Discharge)	1
Total	**1**

Community health inpatient services – Broadfield

Subject	Number of complaints
Admissions and Discharges (Excluding Delayed Discharge)	1
Total	**1**

We asked the trust for updated figures covering quarter 3 2018/19. This trust told us there were no complaints made during that time.

From 1 October 2017 to 30 September 2018 the trust received 10971 compliments. Of these 208 related to community inpatient services, which accounted for 2% of all compliments received by the trust.

(Source: Universal PIR P53 Compliments)

Is this 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 and therapy staff told us local leadership was visible and they knew the managers and their roles. Managers responded to challenges faced by the services.

Haywood Hospital was managed by acting/interim Community Hospitals Manager and Nurse Consultant. The Hospital Matron (community hospital in-patient provision & clinical commissioning group beds), the Service Lead (walk-in centre/minor injuries unit/limb fitting & out of hours GP services), the Team Lead (rheumatology and musculoskeletal service) and the Service Lead (specialist rehabilitation) reported to the hospital manager. Each ward had a ward manager that was a senior nurse.

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.

Trust was formed on 1 June 2018 following a merger between South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Staffordshire and Stoke on Trent Partnership NHS Trust.

The adult community inpatient service had recently reconfigured as the trust had acquired some new services in the care economy and focused its emphasis to partnership working.

The trust mission was 'Together we are making life better for our communities'. The values were: empowering people to improve care and well-being; putting people at the heart of what we do; delivering better health, better care in partnership. People Empowerment Partnership. These appear on the trust web site however we did not see them displayed anywhere on the Haywood Hospital wards l and staff including manager we asked did not really know them.

At the time of our inspection the trust had recently reduced the number of its adult community inpatient locations to one, Haywood Hospital.

We asked the hospital manager what the vision for the service was. They told us it was to provide 'step down' assessment and rehabilitation when local people needed it.

The focus of the trust was on its 'home first' service and approach, if community resources were got right there would be no need for hospital beds. The trust was investing in services in the community. 'Home first' was a trust outreach service from the acute hospitals front door and aimed to prevent hospitalisation, but it had to be timely and this was the challenge. This was towards a 'partnership objective within the trust's strategic framework- 'developing pathways across organisational boundaries to reduce hospital attendance / admission'.

The hospital was aiming to rotate its staff to work in the community also. Key stakeholders were also GP's and their understanding was important to driving the vision but there were high vacancy rates in Stoke on Trent.

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 in all roles we spoke with told us they felt supported by their managers. They said they felt able to speak up without fear of recrimination and they understood their duty of candour to patients when something went wrong. They felt supported by the trust's policy. They were confident in the trust's commitment to make improvement because of incidents and local leaders listened to their views. Staff knew the trust had two 'freedom to speak up guardians.

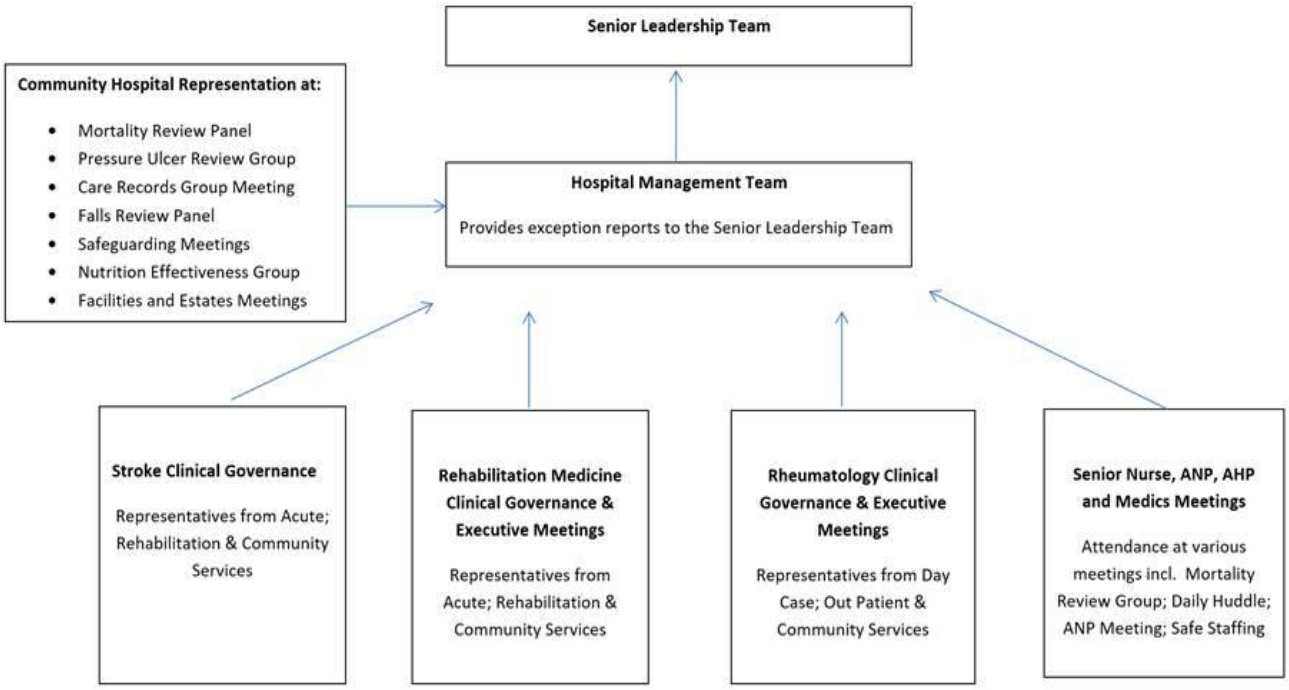
Relationships between staff were supportive and cooperative and staff worked together for the benefit of patients.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The Haywood Hospital governance structure (below) reported to the trust senior leadership team. There were clear lines of accountability from the wards through the monthly hospital managers meeting. For example, we noted from minutes of the monthly Hospital Manager's meeting that ward managers attended regularly and contributed. The meeting ran a working action plan that was colour rated for time lines, so it was clear which action items remained outstanding at any one month.

Ward managers told us the senior nurses shared some of the responsibility for undertaking ward audits. Wards held a monthly staff meeting and there were clinical specialist governance monthly meetings. For example, staff at Broadfield Ward (that provides care for adult patients requiring neurological rehabilitation), told us its own meeting fed up to the Rehabilitation Executive meeting.



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. We found a number of appropriate and effective systems in place to manage risk and all staff were involved within them. The hospital risk register was informed through the regular monthly hospital managers meetings which were informed by monthly ward and specialty meetings.

The Matrons dashboard provided safety and quality data that was reported and analysed at the Hospital managers meeting. A system of peer review and action planning supported wards to improve performance and mitigate risk.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards.

Ward and therapy staff had access to information, policies and procedures through the trust's intranet. However, ward managers had consistently reported issues with recording staff appraisal records on the electronic record system. Service managers also told us the mandatory staff training figures were not reliable for this reason. The service cannot assure the Board through some of its information systems.

Patient records were in paper form. The trust was reviewing how most effectively to integrate electronic records with other community systems and acute provision in the local care economy and to work with partner organisations.

The hospital manager told us as Silver Command they had daily overview through conference calls of tactical requirements to respond to pressures on beds and staffing shortage.

Engagement

We got a strong sense of involvement in the service and pride in the hospital from staff we spoke with at every level and in every role. This included the contract cleaning staff.

Some wards had user involvement committees and patient forums. For example, patient carers, relatives and volunteers from stroke organisations. Ward staff encouraged patients to complete the care experience questionnaire on discharge. This data was analysed by the trust and fed back to the hospital managers meeting and contributed to improvements actions or plans.

Learning, continuous improvement and innovation

Staff confirmed the trust supported continuous professional involvement through appraisals. For example, some nurses had moved through their training at degree level, therapy staff had been offered cognitive behaviour therapy courses.

The clinical lead reviewed research to refresh practice and develop changes within teams if it was not supported by current research.

Community health dental services

Facts and data about this service

Information about the sites and teams, which offer community dental services at this trust, is shown below:

Location / site name	Team/ward/satellite name
Morston House, The Midway, Newcastle under Lyme, Staffordshire	Northern Dental Service
Morston House, The Midway, Newcastle under Lyme, Staffordshire	Personal Dental Service

(Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab)

The trust provided the following information about their community dental services:

The Dental Service provides dental care for vulnerable people and emergency or urgent dental care to anyone not currently under treatment with a dentist locally. The team consists of dentists, dental therapists, dental hygienists and dental nurses.

The service operated from 13 locations. Two of these are within general hospitals where treatment under general anaesthesia is carried out.

Dental services are provided primarily to residents of Stoke-on-Trent and Staffordshire, although emergency and urgent dental care is available to anyone visiting or working in the area. Special care patients are often referred into the service via general dental practitioners or referred on by a dentist within the service.

The following services are provided:

- Emergency or urgent dental treatment
- Out of hours emergency or urgent dental treatment
- Special care dental treatment
- Routine dental care for children

- Epidemiology surveys
- Sedation IV and RA

Emergency/urgent dental care is provided to anyone with dental pain who is not currently with another dentist locally.

Special care dentistry is provided for patients with special needs such as learning disabilities, mental health problems and patients who suffer from dental phobia. This type of dental care typically requires more patient contact time and can involve techniques such as the use of conscious sedation or general anaesthesia.

Epidemiological surveys are carried out as requested.

Anxious patients are referred in by general dental practitioners to have treatment carried out under sedation.

The service provides routine care for children with specific dental needs which include a general anaesthesia service for younger children requiring extractions.

We received feedback from 14 patients and spoke with 25 members of staff. We looked at dental care records for 10 people.

Our inspection between 25 and 27 February 2019 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. During the inspection we visited six out of the 13 locations where dental services are provided from. The services were located in Stoke-on-Trent, Burton-on-Trent, Stafford and Rugeley.

(Source: CHS Routine Provider Information Request (RPIR) – CHS1 Context CHS)

Is this service safe?

Mandatory training

The trust set a target of 90% for completion of mandatory training.

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Corporate Induction	94	96	98%	90%	Yes
Local Induction	94	96	98%	90%	Yes
Mental Capacity Act Level 2	84	87	97%	90%	Yes
Prevent Awareness	90	96	94%	90%	Yes
Adult Basic Life Support	80	87	92%	90%	Yes
Safeguarding Children (Level 3)	78	85	92%	90%	Yes
Equality and Diversity	88	96	92%	90%	Yes
Safeguarding Children (Level 2)	87	96	91%	90%	Yes
Manual Handling - Object	8	9	89%	90%	No
Health and Safety (Slips, Trips and Falls)	85	96	89%	90%	No
Infection Prevention (Level 1)	77	87	89%	90%	No
Safeguarding Adults (Level 1)	84	96	88%	90%	No
Information Governance	83	96	86%	90%	No
Conflict Resolution	74	91	81%	90%	No
Fire Safety - 1 Year	74	96	77%	90%	No

Manual Handling - People	24	87	28%	90%	No

In community dental services the 90% target was met for eight of the 16 mandatory training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Mandatory training for staff included fire safety, infection prevention and control, conflict resolution and resuscitation. Training was accessed through and electronic system and staff showed us how this worked. They were able to monitor their own compliance with their mandatory training through this system. Training was a mixture of hands on and online learning. For example, they arranged for the resuscitation officer to provide resuscitation training to staff within the dental environment. Staff involved in the provision of conscious sedation or general anaesthetic had additional medical emergency training which involved airway management. This is in line with guidance laid out by the Scottish Dental Clinical Effectiveness Programme (SDCEP).

Staff told us they were encouraged to complete training, and this was monitored by managers. Staff received e-mail prompts when training was due to be refreshed. Managers had oversight of when staff were due to complete training and would also prompt them to complete it when required. We were told that they tried to arrange training to be completed during staff meetings. If this was not possible then staff were provided with protected time to complete it.

Safeguarding

The trust set a target of 90% for completion of safeguarding training.

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 3)	78	85	92%	90%	Yes
Safeguarding Adults (Level 1)	84	96	88%	90%	No

In community dental services the 90% target was met for one of the two safeguarding training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

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 at risk 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 at risk, 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.

The trust informed us that there were no safeguarding referrals relating to community dental services.

The trust had policies and procedures relating to the safeguarding of children and vulnerable adults. These were readily available on the trust's intranet page. Staff showed us how to access these. We saw evidence of contact details at each site we visited of the trusts safeguarding team and the local safeguarding team.

All clinical staff were required to complete level three safeguarding children training as part of their mandatory training requirements. Non-clinical staff were required to complete level one safeguarding children training.

Staff had a good awareness of the signs and symptoms of abuse and neglect. Staff provided us with examples of when they had concerns about patients and how these were escalated in a timely manner. It was clear that safeguarding was a fundamental part of the service and staff liaised with health visitors if they had concerns about a child. We were told that health visitors also referred patients to the dental service if they had concerns about their oral health. Staff told us the working arrangements with the health visitors were good.

Cleanliness, infection control and hygiene

Staff were aware of the importance of maintaining a clean and uncluttered environment.

There was a dental specific decontamination policy available on the trusts intranet page. This reflected guidance laid out in the Health Technical Memorandum HTM 01-05 (guidelines for decontamination and infection control in primary dental care) for infection control. Local decontamination was carried out for the reprocessing of contaminated dental instruments and equipment at all clinics which we visited. The clinics follow guidance laid out in HTM 01-05. Staff described to us the end to end procedure for the processing of used instruments. Automated washer disinfectors were used at each site for pre-sterilisation cleaning. Instruments were then sterilised in a validated autoclave and then bagged in pouches. Each pouch was stamped with a use-by date. These processes are in line with guidance laid out in HTM 01-05.

Hand washing facilities and alcohol hand gel were available throughout the clinic areas. Personal protective equipment (PPE) such as gloves and masks were readily available throughout the clinics. We observed staff followed the “arms bare below the elbow” guidance. Hand hygiene audits were carried out monthly. The most recent audits showed a 100% compliance.

Infection prevention and control audits were carried out. The most recent audits showed that the service was meeting the required standards. Infection prevention and control audit service reports were displayed in all waiting areas which showed the most up to date compliance with infection prevention and control including the results of the hand hygiene audit.

Safer sharps were used throughout the service. This is in line with the European Directive for the safer use of sharps. There were suitable arrangements for the storage, collection and disposal of clinical waste.

Staff described the processes for the management of dental unit water lines to help reduce the likelihood of Legionella developing. Dental unit water lines were flushed at the beginning and end of each session and in-between patients. A water conditioning agent was used in the water lines to help prevent to formation of Legionella.

Environment and equipment

Premises and equipment were clean, hygienic and well maintained. This included equipment used in the decontamination of used dental instruments, X-ray machines and surgeries. There were sufficient amounts of dental instruments to support safe and effective care.

A radiation protection folder was maintained at each location which we visited. These had details of the service history of each X-ray machine. All X-ray equipment was up to date with servicing and testing requirements as required by the Ionising Radiation Regulations (IRR 2017). A radiation protection advisor (RPA) and radiation protection supervisor (RPS) had been appointed. We saw evidence of local rules for all X-ray machines which reflected current legislation. We noted at Cross street clinic the local rules for the Orthopantomogram (OPT) machine did not reflect what we found on the day of inspection. The local rules stated that the whole room was deemed to be the controlled area, that the door must be shut when an X-ray is being taken and the patient must be observed when the X-ray is being taken. This would not be possible as there was no viewing window in the door. We were told these local rules were currently being updated.

Medical emergency medicines and equipment were available at each location which we visited. There were some inconsistencies in how these were checked. At some locations there were sealed bags provided by the trust pharmacy department which had an expiry date on them of when it should be replaced. At other locations staff carried out checks on the equipment and medicines themselves. We noted there were no size 4 oropharyngeal airways at Cross street clinic and Stafford Central Hub, there was some out of date oxygen tubing at Meir Primary Care Centre, the paediatric self-inflating bag at Hanley Health centre was dusty and the aspirin at Sandy Lane Health Centre was not dispersible. We noted the glucagon, which is required in the event of severe low blood sugar was not stored in a temperature-controlled environment and the date had not been adjusted accordingly according to manufacturer's guidance. In addition, at Stafford Central Hub there was some out of date adrenaline ampules in the emergency medicine kit. This had not been identified by the checking system in place. Immediate action was taken to obtain in-date adrenaline. After the inspection we were informed that the arrangements for the supply and oversight of medical emergency medicines had been reviewed. The service-level agreement had been transferred. We were told that new process would be consistent across the service and the trust's pharmacy department would have oversight of this.

Assessing and responding to patient risk

During the inspection we looked at example of dental care records. We found that the clinicians checked and recorded patients' medical histories when they attended for treatment. Any medical alerts would be highlighted on the patient's dental care records. These included patients on medications which could cause bleeding.

The service had a system in place to help reduce the likelihood of wrong tooth extraction. This was in the form of a Local Safety Standards for Invasive Procedures (LocSSIP). There were posters up in each surgery which stated Check, Reflect and Perform. This was to ensure staff checked with the notes, treatment plan, the patient and colleagues before the extraction. Then reflect, pause, check again and confirm the correct tooth. And then perform the extraction. Staff were aware of the process and confirmed they followed it.

Staff ensured that patients and carers received appropriate pre and post-operative instructions. This included information about dental extractions and conscious sedation. This helped reduce the likelihood of patients experiencing post-operative complications such as bleeding or infection. Information was provided verbally, and patients were provided with information leaflets.

Staff described the process for dealing with patients who became acutely unwell. This involved trained members of staff assisting the patient. If the patient did not make a timely recovery, then an ambulance would be called. The service carried out domiciliary visits for those who could not attend the clinic. We were told that emergency medicines and equipment were not taken on these visits. We were told that the majority of these visits involved non-invasive dental treatment such as examinations or denture work. However, we were told that on rare occasions invasive treatment such as simple extractions were carried out. We asked if emergency medicines and equipment were taken on these visits and we were told they were not. This had not been formally risk assessed.

Staff were familiar with the signs and symptoms of sepsis. We were told that if any patients presented showing signs of sepsis then an urgent referral would be made to hospital. We saw evidence of posters referring to sepsis in each surgery.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Mercury and blood spillage kits were readily available at all locations which we visited.

Staffing

The trust set a vacancy target of between 8% and 12%. From 1 October 2017 to 30 September

2018, the trust reported an overall vacancy rate of 8% in community dental services. This met the trust target.

A breakdown of vacancy rates by staff group in community dental services at trust level is below:

Staff group	Vacancies	Total staff	Vacancy rate
Support to doctors and nursing staff	4.3	44.4	10%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	53.3	625.6	9%
Public Health & Community Health Services	19.6	236.2	8%
NHS infrastructure support	4.8	59.2	8%
Grand Total	**82.0**	**965.3**	**8%**

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

The trust set a target of 10% to 15% for annual turnover rates. From October 2017 to September 2018enter a date, the trust reported an overall turnover rate of 4% in community dental services. This was below the trust target. A breakdown of turnover rates by staff group in community dental services at trust level is below:

Staff group	Substantive Staff in most recent month	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Public Health & Community Health Services	16.1	1.0	6%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	47.9	1.8	4%
NHS infrastructure support	4.9	0.0	0%
Support to doctors and nursing staff	3.4	0.0	0%
Support to ST&T staff	0.0	0.0	0%
Grand Total	**72.3**	**2.8**	**4%**

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

The trust set a target of 4.8% for sickness rates. From October 2017 to September 2018, the trust reported an overall sickness rate of 5.3% in community dental services. This was higher than the trust target. A breakdown of sickness rates by staff group in community dental services at trust level is below:

Staff group	Most recent month sickness	Total % permanent staff sickness overall
NHS infrastructure support	0.0%	2.5%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	6.0%	5.7%
Public Health & Community Health Services	3.8%	3.6%
Support to doctors and nursing staff	14.4%	6.1%
Support to ST&T staff	-	8.1%
Grand Total	**5.5%**	**5.3%**

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

During the reporting period from October 2017enter a date to September 2018enter a date, community dental services reported that there were no cases where staff have been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Staffing levels at each location we visited were appropriate and we found the teams worked well together. We were told that there were currently some gaps in the service due to sickness, retirement or staff leaving. There was resilience within the workforce to cover for these. Staff were moved between clinics to cover if there were any gaps. We were told that there had not been any instances recently where clinics have had to be cancelled due to staff shortages.

Appropriately trained dental nurses supported the dentists carrying out sedation. Staff involved in the provision of conscious sedation and general anaesthesia were also required to complete additional medical emergency training which involved airway management.

Quality of records

Dental care records were mainly computerised. Any paper records relating to patients were stored in lockable cabinets. These included historical paper records, consent forms, medical history forms and treatment plans. Computers were all password protected and backed up to secure storage to ensure the security of dental care records.

When domiciliary visits were carried out the dentist would record their notes on paper and then transfer them on to the electronic system.

The dental care records which we reviewed were clear, concise and accurate. We saw evidence of a detailed account of an assessment and any treatment which had been carried out on the patient. We saw evidence that the dentists justified, graded and reported on X-rays which were taken. This ensured that the service was acting in accordance with the Ionising Radiation (Medical Exposure) regulations. Patients' medical histories were also recorded and checked each time a patient attended. Markers were used to highlight any allergies or adverse medical conditions.

A record keeping audit had not been carried out under this provider. The last record keeping audit carried out was in July 2018 under the previous provider. The results of the audit showed improvements since the previous record keeping audit. We were told a new audit was due to be completed.

Medicines

Medical gasses used in the provision of inhalation sedation and medicines used in the provision on intravenous sedation were stored appropriately. Gas cylinders were either secured to the wall or attached to the machine used in the provision of inhalation sedation. Midazolam was stored in locked wall mounted cabinets and only certain members of staff had access to these. We saw a controlled drug log was maintained. When we checked these logs, they correlated with the amount of midazolam within the cabinets.

NHS prescription pads were stored securely at each location which we visited. We saw evidence of prescription logs which were maintained. These enabled the service to actively monitor the use and security of prescription pads. Staff were familiar with current guidance about the prescribing of antimicrobials.

Safety performance

There had not been any never events at the community dental services in the previous 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause

serious patient harm or death but neither need have happened for an incident to be a never event. An example of a never event in dentistry is a wrong tooth extraction.

Staff were familiar with the concept of a never event and described the process of how these would be reported.

Incident reporting, learning and improvement

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no never events relating to community dental services.

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community dental services, which met the reporting criteria, set by NHS England between, October 2017 to September 2018.

(Source: Strategic Executive Information System (STEIS))

Staff described to us the process for reporting significant events, incidents and accidents. These were reported on the trusts electronic reporting system. The trusts intranet site had recently been reconfigured and some staff found it difficult to locate where to report incidents. Staff described to us incidents which had occurred within the service. These included abusive patients, medical emergencies and sharps injuries. We were told of a significant event where a GP service had to borrow the defibrillator from the dental department. This had been raised as a significant event and passed to the other relevant organisations.

Incidents were investigated by the clinical director or a manager. We saw evidence of significant events which had been investigated and actions taken to prevent re-occurrence.

Is this service effective?

Evidence-based care and treatment

The clinicians were aware of and followed nationally recognised guidance when providing treatment to patients. This ensured a consistent approach to patient care. Guidance included that laid out by the National Institute for Health and Care Excellence and the Royal College of Surgeons. We reviewed a selection of dental care records which confirmed they followed this guidance.

Conscious sedation was carried out in line with guidance set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care' 2015. We were shown a policy about the use of sedation within the service and this reflected the guidance. We reviewed a selection of records where conscious sedation had been provided. These showed that patients having sedation had important checks carried out first. These included a detailed medical history; blood pressure checks and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. We saw evidence of oxygen saturation checks throughout the procedure and post-operatively to ensure the patient was safe to be discharged.

Staff told us that clinical holding was occasionally used within the service. Several members of the dental team had completed training in the use of clinical holding and provided training to other staff in the service. Staff described examples of when clinical holding had been carried out. This was in the best interest of patients when a patient who lacked capacity attended with acute pain and required treatment. We were told that the patients carer would be fully informed of the process and

would not be carried out unless full consent had been obtained from the patient's carer. The least restrictive means of holding would be used. These steps were in line with guidance laid out by the British Society for Disability and Oral Health.

Nutrition and hydration

Patients undergoing treatment under conscious sedation were provided with advice about fasting. They were told to fast for two hours prior to their appointment. They were provided with verbal and written information about this at the pre-operative assessment appointment. This was then reconfirmed at the treatment appointment.

Patients undergoing general anaesthesia were given appropriate information by staff of the need to fast before undergoing their procedure. The patient, parent or carer were given a pre-operative instruction sheet emphasising the importance of fasting prior to the procedure.

Pain relief

The dentists told us how they decided what method of anaesthesia was required for patients. They took in to account the patient's age, level of cooperation, complexity of treatment and level of anxiety when deciding on the best method of anaesthesia. For example, for a young patient requiring several extractions who had no dental experience a general anaesthesia would be carried out. For less nervous patient's, inhalation sedation or intravenous sedation could be provided. Different options would be discussed with the patient and their carer. We saw documented evidence in dental care records that the different options were discussed with the patient and carer.

Local anaesthesia was used for the relief of pain during dental procedures such as fillings or extractions. Staff told us that topical anaesthetic was always used prior to giving injections.

Patient outcomes

The trust participated in three clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
Community Dental services 6 monthly decontamination self-assessment audit.	12 dental clinics that operate for the Trust	Providing and maintaining a clean and appropriate environment in managed premises demonstrated a high level of compliance. Delivering excellence in patient safety with regards to infection prevention and control processes. Engagement with the infection prevention and control team remains a priority.	Following this report, the Infection Prevention and Control Team continued to work alongside the dental services managers and senior dental nurses to continue to provide standardisation of practice across all areas and strive to maintain the current overall compliance scores.
Baseline Resuscitation Equipment Audit (31) Specialised Services Division Dental Services	SSOTP Dental services	Of the 34 pieces of equipment, 55% (n=19) were fully compliant.	All dental clinics must have two sets of Automated External Defibrillator Pads available. - extra sets of pads to be ordered. Re-audit planned
A Re-audit of the Quality of radiographs taken within Staffordshire Community Dental Service (4.2)	Community Dentistry	The overall standards for Grade 1 were achieved at 85%.	Continue to encourage all radiography qualified staff to maintain their competencies and contribute to the audit.

		The overall standards for Grade 2 were within the <20% range at 14% across the 3 x-ray types. The overall standards for Grade 3 were within the <10% range at 1% across the 3 x-ray types. Compared to last year, and following on from the training provided, staff citing 'processing troubleshooting' as an area for personal development has markedly reduced.	Continued vigilance in reducing the number of patient and film positioning errors.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

The service used audit to monitor the quality and safety of treatment being provided. Audits included radiography, dental care records and infection prevention and control. Audits all had action plans and outcomes. Where issues had been identified then these were disseminated to staff and discussed to continually encourage improvements. Staff told us that they were aware of the audit results which affected them.

The service was involved in carrying out epidemiology surveys with Public Health England. This was to assess the dental health of five-year old children in the local area. Staff told us that they had noticed a difference in the oral health in the children who were examined between the north and south regions. The results of the survey would be collated to provide Public Health England to identify the areas of greatest dental need.

Competent staff

The service could not provide evidence that monthly staff clinical supervision was being undertaken as per their policy. It meant managers were unable to demonstrate how they had managed the impact of incidents and discussed lessons learnt with individual staff members.

From April 2018 to November 2018 , 79% of permanent non-medical staff within the community dental services core service had received an appraisal compared to the trust target of 90%.

Community dental services – Morston House

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
NHS infrastructure support	5	5	100%	90%	Yes
Support to doctors and nursing staff	4	4	100%	90%	Yes
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	52	59	88%	90%	No
Public Health & Community Health Services	9	21	43%	90%	No
All staff	**70**	**89**	**79%**	**90%**	**No**

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

Staff had the skills and qualifications to carry out their roles effectively and in line with best

practice. Many dental nurses had additional qualifications such as radiography, sedation and special care dentistry. These additional qualifications were used within the service to cater for the ever-increasing complexity of the patient base.

All staff involved in the provision of conscious sedation had completed either immediate life support training or additional medical emergency training which involved airway management. This ensured staff had the skills and competency to deal with any medical emergencies which may occur when being sedated.

Staff had annual appraisals. They told us that these were beneficial and a positive experience. We were told that training needs and requirements were discussed at these. One dental nurse told us that they had been put on the sedation course as a result of discussions during an appraisal.

Staff told us that they felt well supported by the more senior clinicians. They told us they were able to approach them for advice or support and said they were readily available.

Multidisciplinary working and coordinated care pathways

The service worked collaboratively with other healthcare professionals to understand and meet the range and complexity of people's needs.

Multidisciplinary working was used throughout the service. Staff described examples of when multidisciplinary working was used. For example, when treating special care patients, they would work with the trust's learning disability team to assist in making reasonable adjustments and arranging transportation for patients. Staff told us they had a good working relationship with the learning disability team. If a special care patient was due to have general anaesthetic for dental treatment, then they would liaise with the patients GP to see if any blood tests were required which could be done at the same time. They would also check with the patient's carer to see if any other treatments were required such as podiatry services.

The service used dental hygiene therapists. Dental hygiene therapists are qualified dental professionals who can carry out treatments such as fillings and extraction of deciduous teeth. We spoke with a dental hygiene therapist who told us that they felt fully involved in the dental team and played an important role in patient care.

Referrals were received into the service from dentists, GPs or other healthcare professionals. Currently referrals were received either on paper or through an electronic online system. As of 31 March 2019, all referrals would be electronic. All referrals were initially triaged by one of the dentists to determine which clinic and clinician would be best suited for the patient. The referring clinician would be kept up to date with what treatment had been planned and carried out. If the patient was to be discharged back to primary care, then a discharge letter was sent outlining the importance on ongoing management of the patient.

Health promotion

Staff were aware of and applied the principals of the Department of Health's 'Delivering Better Oral Health' toolkit 2013 when providing preventative advice to patients on how to maintain a healthy mouth. This is an evidence-based tool kit used for the prevention of the common dental diseases such as dental caries and periodontal disease. Staff told us that they provided oral hygiene advice, toothbrushing instruction, fluoride applications, smoking cessation advice and prescribed high fluoride toothpaste. We saw evidence of this in the dental care records to support this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust set a target of 90% for completion of Mental Capacity Act training. From 1 April 2018 to 30 November 2018 the trust reported that Mental Capacity Act (MCA) training had been completed by 97% of staff within community dental services.

Staff were aware of the importance of obtaining and documenting consent to treatment. Staff described the process for obtaining consent from patients. This included providing them with the options and the risks associated with the different options. We saw evidence of this documented in the dental care records. This also included discussion about the different types of anaesthesia which would be used such as local anaesthetic, conscious sedation and general anaesthesia. The service used NHS consent forms and staff were aware of the different types of consent form which were available and where each one would be used. We saw examples of completed NHS consent forms in patient's dental care records.

Patients undergoing conscious sedation provided consent at a pre-assessment appointment. This was then re-confirmed at the treatment appointment. This is in line with guidance set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care' 2015.

Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005. They were required to complete training about the Mental Capacity Act. Staff told us they took all reasonable steps to help patients consent for themselves. If this was not possible then the person with legal responsibility for the patient would be involved. For complex cases or those who are unfriended then a best interest meeting would be held. This could involve the patients GP, health visitor, carer and any other person close to the patient.

Staff were aware of the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Is this service caring?

Compassionate care

Staff treated patients with dignity and respect and were friendly and compassionate towards them. Patients commented that staff were friendly, amazing, cheerful and fantastic. They also commented that they were made to feel at ease when having treatment and many commented that they were particularly good at helping anxious children.

Results of the NHS Friends and Family Test from February 2019 showed that at all clinics, over 80% of patients who responded would recommend the service to friends and family. At Stafford Central Hub, Bentilee Neighbourhood Centre and Tunstall Health Centre 100% of patients would recommend the service to friends and family.

Staff were aware of the importance of privacy and confidentiality. For example, surgery doors were held closed when patients were having treatment and there was no patient identifiable information left where others may see it. The layout of the reception and waiting areas provided some privacy when staff were dealing with patients. If a patient required more privacy, then a private room would be found for any private conversations.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. Patients confirmed that staff were supportive during treatment and had a good rapport with them which made them feel at ease. During our visit we witnessed staff helping a special care patient whilst having an X-ray taken. They spent time to support and explain what was going to happen and answering any questions the patient had to make them feel at ease.

We were told by staff that to help acclimatise patients they would offer them a walk round session of the clinic before attending for their first appointment. This enabled the patient to become familiar with the environment and staff told us that many patients found this helpful in reducing their anxiety.

Clinical staff told us that they had the freedom to change the length of their appointments, so they had enough time to provide emotional support to their patients. They also offered patients appointments at different times of day. For example, some patients may be better suited and more co-operative in the morning.

Understanding and involvement of patients and those close to them

Patients and their families were appropriately involved in and central to making decisions about care options and the support needed. Patients told us that they felt fully involved in decisions about treatment. They told us that they were given good and clear information about treatments in a way they understood.

Staff had developed an easy read general anaesthetic walkthrough book. This had pictures of the different stages and simple descriptions of the general anaesthetic process. This was used when children were due to have a general anaesthetic for treatment. Staff told us that children found this picture book helpful when preparing for a general anaesthetic.

Staff described to us the different methods which they used to help patients understand treatments. These included photographs, models and X-ray images. These would be shown to the patient or carer to help them better understand the disease process and any treatments which could be provided.

Is this service responsive?

Planning and delivering services which meet people's needs

The dental service was commissioned by NHS England. Services were planned to meet the needs of people who could not access primary dental care services. These included patients with medical, physical or social issues, patients with dental anxiety and those requiring emergency dental treatment.

Reasonable adjustments had been made at all the locations which we visited. All locations were fully accessible for wheelchair users. Other facilities included accessible toilets with hand rails and a call bells and lowered reception desks. The service had access to hoists to assist wheelchair users to get into the dental chair. Staff had been appropriately trained in the use of hoists and described a consistent and safe process for hoisting patients.

Translation services (both face to face and telephone) were available for patients who did not have English as a first language. We saw notices in the reception areas, written in languages other than English, informing patients translation service were available. Some members of staff were also multilingual and could speak languages such as Russian, Polish, Punjabi and Slovakian. Staff also told us that some of them had completed Makaton and sign language training.

There were adequate seating facilities in the waiting areas at all clinics.

Meeting the needs of people in vulnerable circumstances

The service was configured to reflect the needs of vulnerable people. It was a referral service providing either continuing care or a single course of treatment to children or patients with special needs due to physical, mental, social and medical impairment.

Domiciliary visits were carried out by the service. These visits were reserved for patients who could not access the service due to medical, physical or social issues.

Staff at Cross Street Clinic saw patients from the local substance misuse service. They ensured that appointment times were arranged around the specific needs of the patient. This included considering when the patient had their dose of methadone. This ensured that the patient had the capacity to consent for treatment.

Staff also told us they had a good working relationship with the safeguarding team and health visitors. Patients who the safeguarding team or health visitors had dental concerns about could be referred directly into the service for treatment.

Access to the right care at the right time

The largest ethnic minority group within the trust catchment area is Asian/Asian British with 12% of the population.

	Ethnic minority group	Percentage of catchment population
First largest	Asian/Asian British	12.3%
Second largest	White Other	8.0%
Third largest	Mix heritage	4.3%
Fourth largest	Black/Black British	2.7%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

General dental practitioners and other health professionals could refer patients for short-term specialised treatment as well as long term continuing care to the community dental service. Once a course of treatment had been completed the patient was referred to primary dental care for ongoing care with their own dentist if appropriate.

Waiting times were actively monitored by the dental service manager. Updated referral times were four weeks from referral assessment appointment. Waiting times for treatment under general anaesthetic varied between the north and south regions. The waiting list for general anaesthesia in the south was approximately three months for both children and special care adults. In the north is was three weeks for children and ten weeks for special care adults. Patients in the south area were informed of the waiting list and were offered an appointment in the north area if they wished to reduce their waiting time. Where urgent care was identified then earlier appointments could be arranged.

The service offered emergency or urgent dental care both in hours and out of hours. Patients were sent to the service through the NHS 111 service. The service also ran the Staffordshire Dental Advice Line. This was a service which provided advice and where necessary treatment to patients who were not registered with a dentist. Staff described the triage process for this service and told us how they triaged patients in to emergency care, urgent care and routine care depending on the patient's symptoms.

Learning from complaints and concerns

From 1 October 2017 to 30 September 2018 there were two complaints about community dental services. The trust took 65 days to investigate and close one complaint, the other was still under investigation. This is not in line with their complaints policy, which states complaints should be dealt with within 35 (Staffordshire and Stoke-on-Trent partnership trust) or 25 (South Staffordshire and Shropshire Healthcare NHS Foundation Trust) working days.

A summary of complaints within community dental services by subject and site is below:

Subject	Number of complaints
Values and Behaviours (Staff)	1
Patient Care	1
Total	**2**

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

The service took complaints and concerns seriously. There was a trust complaint policy and procedure which staff were aware of. There were details of how a patient could make a complaint

displayed in the waiting areas this included the details of the Patient Advice and Liaison Service (PALS). Staff aimed to address any informal complaints in house initially. If the patient was not satisfied with the response, then they would be signposted to the trust's complaints team.

We reviewed documentation of one complaint which the service had received. This had been dealt with through the trust's formal complaints process. We saw that they had responded to concerns appropriately. We noted that details of the patient's complaint were held within the patient's dental care records. This is not in line with standards laid out by the General Dental Council. We were told that the storage of complaints would be reviewed to ensure they did not form part of their individual dental care records.

Is this service well-led?

Leadership

There was a clear, well-defined management structure in place. Leaders had the skills to deliver high-quality, sustainable care.

Clinical leadership was provided by the clinical director. They were supported by senior dental officers who had individual lead roles within the service such as for general anaesthetics and conscious sedation. The dental service manager and deputy manager were responsible for the day to day running of the service. There were senior dental nurses responsible for each location who were responsible for the management of the dental nurses at each location.

Staff told us that they felt appreciated and part of a team and leadership positively encouraged this. They were encouraged to adopt individual roles such as lead roles for the epidemiology studies and clinical holding. They told us that leaders were visible, supportive and approachable.

Vision and strategy

The service had a clear vision and strategy with objectives. The objectives were to maintain and improve the delivery of safe, high quality dental services and develop the service to become the provider of choices when the services are to be procured. There were systems in place to help them achieve these objectives which included developing the governance processes and workforce development.

The trusts values were "lead by example", "respectful", "honest and trustworthy", "caring and compassionate" and "listen and engage".

Culture

Staff morale was generally good across the service. They were proud to work within the service and spoke positively about the new provider. There was good teamwork within the service. Many staff had worked in the service for several years. They felt listened to by management and felt able to put forward ideas of how to improve the service and make it better for staff. For example, modifying staff roles to take into account medical or physical issues.

Staff were aware of their responsibilities to raise concerns if the need arose. They were aware of the whistleblowing process and could easily access the policy. They were aware of the freedom to speak up guardian and could access their details on the trust's intranet. They also had an awareness of the need to be open and transparent with patients in line with the duty of candour.

Governance

The trust provided policies and procedures to provide guidance for staff. These were readily available on the trust's intranet page. Staff demonstrated how they accessed these policies. There

were also dental specific policies such as for conscious sedation and the decontamination of re-usable instruments.

There were systems in place to ensure information is disseminated to all staff. There were quarterly service meetings. These were held separately for the north and south teams. At these meetings there were separate clinic meetings and clinician meetings. Then after these there were whole team meetings. Staff told us they found these meetings useful and enjoyed them. At Christmas each year they attended a whole team meeting where training was also provided to cover different topics such as compliance or safeguarding. Senior dental nurses held quarterly meetings covering the north and south regions. This was an opportunity to discuss good ideas, concerns and best practice. This also linked in with the infection prevention and control meetings. Weekly informal senior management meetings were held involving the clinical director, dental service manager and the deputy manager. Topics such as the risk register, training, incidents, complaints and staffing levels were discussed.

Improvements could be made to the processes for the checking of the medical emergency medicines and equipment. There were some inconsistencies between the north and south areas. We found some out of date adrenaline in the medical emergency kit at Stafford Central Hub and out of date equipment at Meir Primary Care Centre. In addition, there was a missing item in the medical emergency kit at Cross street clinic and Stafford Central Hub. We noted that the glucagon at the locations we visited where we could examine the medical emergency medicines had not had the date adjusted to reflect the fact it was not stored in a temperature-controlled environment. After the inspection we were informed that the arrangements for the supply and oversight of medical emergency medicines had been reviewed. The service-level agreement had been transferred. We were told that new process would be consistent across the service and the trust's pharmacy department would have oversight of this.

Management of risk, issues and performance

A comprehensive risk register was maintained. This was reviewed on a regular basis and was discussed at senior management meetings. The risk register was used to monitor and manage known risks to the service. Actions were put in place and these were allocated to individuals to follow up. We saw evidence that review dates were set to check actions had been completed and review if there had been any increase or reduction in the risk. Current topics on the risk register were the lack of X-ray facilities at the Stonydelph and Cannock clinics, lack of scavenging at Bentilee Neighbourhood Centre and the storage of oxygen cylinders at Hanley Health Centre. We saw evidence that risks had been appropriately managed.

Information management

Staff told us they had access to all the information they needed to provide care to patients. Dental care records were mainly computerised. Staff could access the dental care records from different clinics. This enabled them to see patients at different clinics and be aware of any history relating to the patient such as previous treatment which has been provided or any adverse medical conditions.

Staff had completed training in information governance and were aware of the importance of protecting patients' personal information.

We saw computers were password protected and were told these were backed up to secure storage. Any paper records were stored in lockable cabinets. We saw staff locked computers when they moved away from their workstations.

Engagement

The service engaged with patients, staff, other healthcare professionals and external stakeholders well to help improve the quality and safety of the service.

Several members of the dental team attended the local dental committee meetings. These are groups of dentists working in the NHS who act as a representative body for dentists in the local area with regards to the planning and commissioning of NHS dentistry. The clinical director also attends the local dental network. Local dental networks are a key part of providing multidisciplinary sustainable leadership for the NHS and work across commissioning and provider services.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used. The Friends and Family Test was also combined with a service specific patient survey where questions about how satisfied they were with the quality of treatment, whether they felt listened to, whether they had enough time to discuss their condition and whether they knew how to contact an out of hours dentist. Feedback from the surveys was discussed at staff meetings. Feedback from patients was generally very positive about the service being provided.

Staff told us they received weekly newsletters and e-mails from the trust about general news and trust business. If the service has received any formal compliments, then these can be featured in the newsletter. The trusts also carried out a staff survey. The latest staff survey had just been completed and they were awaiting the results of this. We saw evidence of a staff survey from the previous provider. There was an action plan in place to address any concerns which had been highlighted in this survey such as improving the quality of appraisals and supporting opportunities for flexible work.

Learning, continuous improvement and innovation

Learning and continuous professional development was central to the service. Many of the dental nurses had completed additional qualifications such as sedation, radiography and special care dentistry.

The service provided training to undergraduate dental students from the University of Birmingham. This was part of an outreach programme which enabled undergraduate dental to get experience in community dental settings. They also allowed school aged children who were interested in following a career in dentistry to observe. This was fully risk assessed to ensure the student was fully aware of the obligations to maintain patient confidentiality. We saw a thank you card from a recent work experience student which was praising the staff for helping them and being so welcoming.

The service was currently working with Public Health England to carry out epidemiology surveys. This was to assess the dental health of five-year old children in the local area. Staff spoke passionately about this survey and thoroughly enjoyed visiting the local schools to carry it out.

Urgent care

Facts and data about this service

The Trust operates two services classed as Urgent Care facilities these are a walk-in centre at Haywood Hospital and a minor injuries unit at the Leek Moorlands hospital.

The walk-in centre is a nurse-led service which provides a range of minor injury/ailment services, no appointment is needed, and the facility is used by approximately 55,000 patients a year. The walk-in centre also provides a daily Deep Vein Thrombosis service and a fracture clinic service which operates three afternoons each week.

The opening hours for the walk-in centre are:

- 7am to 9.30pm Mon- Fri

- 9am to 9.30pm Sat/Sun/Bank Holidays

The minor injuries unit provides the first point of call for assessment of minor injury and illness; it is open between 8am and 8pm and provides a nurse-led minor injury and minor illness facility.

Services provided include:

- Advice for bites, stings allergy related issues
- Advice/treatment for muscle and joint injuries e.g. sprains and strains
- Assessment, diagnosis, and treatment for broken bones/fractures
- Emergency contraception and advice
- Treatment of ear, throat, urine, eye, and some skin infections
- Wounds needing insertion/removal of stitches and special care
- X-ray facilities

Is this service safe?

Mandatory training

Although staff were up-to-date with most available mandatory training, the service did not supply training in all key skills for all staff. It did not ensure all staff had time to complete modules during work hours.

The trust set a target of 90% for completion of mandatory training. In community urgent care services, the 90% target was met for 10 of the 15 mandatory training modules for which all staff were eligible.

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Conflict Resolution	43	44	98%	90%	Yes
Local Induction	43	44	98%	90%	Yes
Corporate Induction	43	44	98%	90%	Yes
Mental Capacity Act Level 2	36	37	97%	90%	Yes
Adult Basic Life Support	35	37	95%	90%	Yes
Safeguarding Adults (Level 1)	42	44	95%	90%	Yes
Equality and Diversity	41	44	93%	90%	Yes
Health and Safety (Slips, Trips and Falls)	41	44	93%	90%	Yes
Safeguarding Children (Level 2)	41	44	93%	90%	Yes
Prevent Awareness	40	44	91%	90%	Yes
Information Governance	39	44	89%	90%	No
Manual Handling - Object	6	7	86%	90%	No
Fire Safety - 1 Year	37	44	84%	90%	No
Infection Prevention (Level 1)	30	37	81%	90%	No
Manual Handling – People	17	37	46%	90%	No

Total	**534**	**595**	**90%**	**90%**	

The service compliance of manual handling training was low and did not meet the trust target.

Staff did not always have time to complete mandatory training. Although most staff had completed their mandatory training, they said it was sometimes difficult to find time to do this during working hours. As most training was online, staff said they completed training in their own time at home instead.

The trust did not supply detailed sepsis training for staff in the urgent care departments on a recurring basis. The service supplied infection control training for staff which had a brief overview of sepsis. Managers said that they supplied a sepsis awareness session for staff recently, which was more detailed. The service supplied us with information about the sepsis awareness session that supported what managers told us. This training was supplied during the year April 2016 to March 2017 and was face-to-face. At Leek minor injuries unit, 18% of staff had attended the training and 54% of staff attending at the Haywood walk in centre. This was a one-off session. There was a policy and tool for the staff to follow.

The service did not carry out medical emergency scenario drills, and only some staff had training in paediatric life support. Some staff at both units undertook adult intermediate life support training. For the year 2018, 89% staff at the Haywood walk in centre had completed the training. In the same period 100% of the staff at Leek minor injuries unit had completed training. Some staff at both units undertook paediatric intermediate life support training. For the year 2018 78% of staff at both units had received training.

The service did not supply training for staff in mental health issues, dementia or learning disabilities. Staff told us they did not receive training in any of these topics and the trust did not supply any training information.

Managers had a system to monitor whether staff were up-to-date with mandatory training. They received an alert from the training department, and in turn they would remind staff to attend training. Individual staff members also received an email alert when mandatory training was due.

The trust kept a training record for staff who had attended training. Managers discussed mandatory training at the management meeting which the service lead attended monthly. The meeting noted that staff did not have time to access some of the mandatory training they needed. It was minuted that managers would review where training was delivered to see if it could be delivered on site to improve attendance.

A breakdown of compliance for mandatory training courses from 1 April 2018 to 30 November 2018 for qualified nursing staff in community urgent care services is shown below:

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Conflict Resolution	29	29	100%	90%	Yes
Corporate Induction	29	29	100%	90%	Yes
Local Induction	29	29	100%	90%	Yes
Adult Basic Life Support	28	29	97%	90%	Yes
Equality and Diversity	28	29	97%	90%	Yes
Health and Safety (Slips, Trips and Falls)	28	29	97%	90%	Yes
Mental Capacity Act Level 2	28	29	97%	90%	Yes
Prevent Awareness	28	29	97%	90%	Yes
Safeguarding Adults (Level 1)	28	29	97%	90%	Yes
Safeguarding Children (Level 2)	28	29	97%	90%	Yes
Fire Safety - 1 Year	25	29	86%	90%	No
Information Governance	25	29	86%	90%	No

Infection Prevention (Level 1)	23	29	79%	90%	No
Manual Handling - People	13	29	45%	90%	No
Total	**369**	**406**	**91%**	**90%**	

In community urgent care the 90% target was met for 10 of the 14 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from 1 April 2018 to 30 November 2018 for medical staff in community urgent care services is not available as there are no medical staff in this service.

Community urgent care services- Haywood Hospital

A breakdown of compliance for mandatory training courses from 1 April 2018 to 30 November 2018 for qualified nursing staff in community urgent care services at Haywood Hospital is shown below:

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Conflict Resolution	23	23	100%	90%	Yes
Corporate Induction	23	23	100%	90%	Yes
Local Induction	23	23	100%	90%	Yes
Adult Basic Life Support	22	23	96%	90%	Yes
Equality and Diversity	22	23	96%	90%	Yes
Health and Safety (Slips, Trips and Falls)	22	23	96%	90%	Yes
Mental Capacity Act Level 2	22	23	96%	90%	Yes
Prevent Awareness	22	23	96%	90%	Yes
Safeguarding Adults (Level 1)	22	23	96%	90%	Yes
Safeguarding Children (Level 2)	22	23	96%	90%	Yes
Information Governance	20	23	87%	90%	No
Infection Prevention (Level 1)	19	23	83%	90%	No
Fire Safety - 1 Year	19	23	83%	90%	No
Manual Handling - People	9	23	39%	90%	No
Total	**290**	**322**	**90%**	**90%**	

At Haywood Hospital community urgent care services, the 90% target was met for 10 of the 14 mandatory training modules for which qualified nursing staff were eligible.

Community urgent care services- Leek Moorlands Hospital

A breakdown of compliance for mandatory training courses from 1 April 2018 to 30 November 2018 for qualified nursing staff in community urgent care services at Leek Moorlands Hospital is shown below:

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Conflict Resolution	6	6	100%	90%	Yes
Corporate Induction	6	6	100%	90%	Yes

Local Induction	6	6	100%	90%	Yes
Adult Basic Life Support	6	6	100%	90%	Yes
Equality and Diversity	6	6	100%	90%	Yes
Health and Safety (Slips, Trips and Falls)	6	6	100%	90%	Yes
Mental Capacity Act Level 2	6	6	100%	90%	Yes
Prevent Awareness	6	6	100%	90%	Yes
Safeguarding Adults (Level 1)	6	6	100%	90%	Yes
Safeguarding Children (Level 2)	6	6	100%	90%	Yes
Fire Safety - 1 Year	6	6	100%	90%	Yes
Information Governance	5	6	83%	90%	No
Infection Prevention (Level 1)	4	6	67%	90%	No
Manual Handling - People	4	6	67%	90%	No
Total	**79**	**84**	**94%**	**90%**	

At Leek Moorlands Hospital community urgent care services, the 90% target was met for 11 of the 14 mandatory training modules for which qualified nursing staff were eligible.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had received the recommended training on how to recognise and report abuse. However, showed a good understanding of how to recognise abuse, who to refer to and how to report. We saw safeguarding referral information on posters in the consultation rooms, which showed staff what to do once they had recognised possible abuse and how to go about doing it. We spoke with staff and they explained the process clearly.

The provider had a children's and adult safeguarding policy that was in date. The policy had child protection referral information, how to report a concern of domestic abuse, it outlined staff responsibilities and that safeguarding training was mandatory.

Most staff had not received training in safeguarding at level 3. Some staff told us they had recently attended level 3 training in child and adult safeguarding and felt it was of a good quality. They said it enabled them to recognise all forms of abuse. The provider supplied safeguarding level 3 training information. This training had only started in January 2019 and the leaders of the service felt this was not necessary before this date. The training need had been identified by the head of strategic safeguarding who noted the absence of safeguarding training at level 3 for the urgent care service as an omission following the transfer of the service in June 2018. Since January 2019 32% of staff working at the Haywood walk in centre had completed safeguarding level 3 training, and 50% of staff working at Leek minor injuries unit had completed safeguarding level 3 training.

The trust had previously trained staff to level 2 and had set a target of 90% for the completion of safeguarding training. A breakdown of compliance for safeguarding training courses at level 2 from 1 April 2018 to 30 November 2018 for all staff in community urgent care services is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults Level 2	42	44	95%	90%	Yes
Safeguarding Children Level 2	41	44	93%	90%	Yes

A breakdown of compliance for safeguarding training courses level 2 from 1 April 2018 to 30 November 2018 for qualified nursing staff in community urgent care services is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults Level 2	28	29	97%	90%	Yes
Safeguarding Children Level 2	28	29	97%	90%	Yes

In community urgent care services, the 90% target was not met for both safeguarding training modules for which qualified nursing staff were eligible, as staff were eligible for level 3 training as well as level 2.

Community urgent care services- Haywood Hospital

A breakdown of compliance for safeguarding training courses level 2 from 1 April 2018 to 30 November 2018 and level 3 at February 2019, for qualified nursing staff in community urgent care services at Haywood Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults Level 2	22	23	96%	90%	Yes
Safeguarding Children Level 2	22	23	96%	90%	Yes
Safeguarding Children Level 3	9	28	32%	90%	No

The 90% target was not met for both safeguarding training modules for which qualified nursing staff in community urgent care services at Haywood Hospital were eligible. This is because any healthcare practitioner that assesses, plans and delivers treatment, should be trained in safeguarding for children at level 3.

A breakdown of compliance for safeguarding courses from 1 April 2018 to 30 November 2018 for medical staff in community urgent care services at Haywood Hospital is not available as there are no medical staff in this service.

A breakdown of compliance for safeguarding training courses level 2 from 1 April 2018 to 30 November 2018 and level 3 at February 2019, for qualified nursing staff in community urgent care services at Leek Moorlands Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Adults Level 2	6	6	100%	90%	Yes
Safeguarding Children Level 2	6	6	100%	90%	Yes
Safeguarding Children Level 3	3	6	50%	90%	No

The 90% target was not met for level 3 safeguarding training for which qualified nursing staff in community urgent care services at Leek Moorlands Hospital were eligible. This is because any healthcare practitioner that assesses, plans, and delivers treatment should be trained in safeguarding for children at level 3. This training need had been identified by the previous provider but not addressed.

The service had systems to identify safeguarding and child protection issues and staff knew how to access support if required but had not used it.

The trust informed us that there were no safeguarding referrals relating to community urgent care services. Staff could not tell us of any safeguarding referrals for adults or children ever at either of the units. This was of concern as the Haywood walk in centre served the entire population of

Stoke-on-Trent and saw a high volume of patients. We would expect the service to have made some safeguarding referrals in the period reported.

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 at risk 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 at risk, 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.

The service used a child protection screening tool for all patients aged zero to 19 and expectant mothers for safeguarding issues. They recorded this in the patient notes in all cases. They formed part of the child protection information systems (CPIS). This meant that the safeguarding authority was made aware of when notes were accessed for any individual in the child protection system.

Staff knew that there was a trust lead for children who they could access for support if they needed to.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, the environment and equipment clean. They used control measures to use prevent the spread of infection. The service followed The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections. However, we did not have assurance that sterile procedures were carried out in line with National Institute Clinical Excellence (NICE) guidelines, such as re-catheterisation.

Staff cleaned the environment and equipment to a high standard. We saw that all areas were clean, tidy, and free of clutter and dust. We saw that cleaning rotas had been fully completed by staff. We reviewed cleaning audits which showed that cleaning had been completed at all times.

Staff used infection control measures to prevent the spread of infection. We saw all staff washing hands in between patients and wearing protection when carrying out procedures that held a cross infection risk. All clinical areas had hand washing facilities, hand washing technique posters and hand gel. Hand gel was also available in the nonclinical areas of both departments.

The provider undertook infection control audits in the urgent care units. The trust supplied us with infection control audits from 2018.

Environment and equipment

The service had suitable equipment, mostly suitable premises and looked after them well.

The patient environment was compliant with the Royal College of emergency medicine best practice guidelines (2017). All furniture was appropriate and in a good state of repair.

Both units were accessible for patients with mobility impairment and there were baby changing facilities. There were no designated breastfeeding rooms, but staff told us that they would find an appropriate comfortable room for anyone requesting this. The service offered seating for those with disabilities and for those who needed a larger chair. Patients could access disabled toilets that were situated just outside of the walk-in centre waiting rooms at both sites.

The service was compliant with the Medicines and Healthcare products Regulatory Agency (MHRA) guidance on managing medical devices (2015). Emergency equipment was available, staff maintained and checked it regularly. All medication for emergency situations was available and was in date.

The service had several dedicated consultation rooms and treatment rooms at Leek minor injuries and at the Haywood walk in centre. All consultation rooms were well equipped for the assessment of patients. For example, staff had neurological testing equipment, scales and height measures, body mass index (BMI) charts, ophthalmoscope and auroscopes (equipment for testing eyes and ears) and blood sugar testing equipment.

The treatment room was fully equipped and set up to deliver a range of treatments. They had wipeable examination tables, trolleys for carrying out procedures such as dressings, and wound suturing. There was a storage room that the staff kept stocked with a range of consumables for patient treatments. The consumables were packaged appropriately and all in date. The service did not have a slit lamp for emergency eye problems, however they had particularly good access to two local ophthalmologists who provided this service. The service did not have a walking boot for those with a fracture of the lower limb and who could not use crutches. The trust supplied information to explain this, the service used the fracture guidelines of the local acute NHS trust emergency department as part of their contractual arrangements, which said that this was not recommended.

The service did not provide separate waiting areas for children at either unit. Children waited with adults at both units in the main waiting rooms.

The service had mixed levels of security arrangements. The trust provided security staff at the Haywood walk in centre and they were visible at the time of inspection. The security staff were placed in a position where they would be able to see any acts of violence or aggression in the walk-in centre waiting rooms. All rooms that were situated away from the waiting area were equipped with an alarm system. The trust did not provide security staff at Leek minor injuries unit. The reception staff had personal alarms which they said they would use if necessary and they would call 999 to alert the police. Healthcare professionals were not aware of a system to call for help if there were acts of violence or aggression against them in the rooms away from reception. Staff at Leek minor injuries unit said they had never had a security issue that they could remember.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. There was no triage system or policy in place.

The service did not meet the standard for the triage of patients within 15 minutes of arrival as directed in the Royal College of Emergency Medicine (RCEM) best practice guideline-Initial assessment of emergency department patients (2017).

Patients were not routinely triaged within 15 minutes of arrival at both units by a health care professional. The receptionists took a history and were aware of some simple symptoms that patients presented with that they should go and speak to healthcare professional straightaway about. The reception staff had not received training in red flags recognition.

We checked 17 records that confirmed this system. There were three patients with symptoms that the receptionist felt required urgent review, and these were seen and triaged within zero, 23 and 26 minutes. We saw this on the day of inspection, where a child with a head injury presented to reception and the receptionist alerted a healthcare professional. However, we also saw a patient attend with a severe injury that needed immediate attention who waited to be seen for 50 minutes. Once staff had seen this patient they sent them urgently to the emergency department.

There were 14 patients who were not triaged and waited for an initial assessment between 11 minutes and one hour 50 minutes. Staff told us that there was a dedicated triage room however this was not fit for use following an assessment by the health and safety team.

There was a difference of opinion about the need for a triage system, at the time of the inspection. Managers told us that having a triage system would mean that patients would be seen twice, and this would affect waiting times. The service intended to look at developing streaming at the

Haywood walk in centre to separate the queues for minor injuries and minor illness. Managers were unclear about the need to follow the standards for national triage times, however they did acknowledge the gap. Staff told us they did not have time to triage and then see patients again due to staffing issues.

A small number of staff told us they felt comfortable with the system they used as receptionists were experienced. They had not had any patients who had become very unwell whilst waiting to be seen who had not been triaged. Most staff felt uncomfortable that they did not have a triage system as this meant they did not know if there were patients with red flags waiting to be seen.

The service responded to our urgent request for a review of triage of a patient by healthcare professional within 15 minutes of arrival, after the inspection. Managers told us that staff were writing the standard operating procedure (SOP) for their current process of managing attendances presenting with red flags; they told us that the trust would sign this off and implement it within one week. In the interim, they had reminded all administrative staff what constitutes a red flag and confirmed this via email. They told us they were reviewing training needs and would provide training for all staff (clinical and administrative) across both sites, so that they were clear about what a red flag was and their roles and responsibilities in managing them.

Managers supplied us with information that demonstrated they had reviewed the electronic patient information system to support triage. This showed that the service implemented a triage record system on the 11 March 2019. The service told us they would implement a triage process across both sites for all patients attending and formalise the protocol for this. They supplied us with patient information about the new triage process, including a review of the staffing model.

The provider had a draft standard operating procedure for sepsis which the urgent care units followed. The trust was in the process of approving this. It was reviewed at the policy and procedures committee on 21 February 2019.

There was a screening tool for sepsis. Staff told us they took observations and used an early warning system which gives a score to trigger further action or review. Early warning scores for adults and children reference charts were in the clinical rooms where staff assessed patients. We saw that staff recorded observations in all the electronic patient records that we reviewed, however we did not see any early warning scores recorded.

Staff recorded all other patient risk information; however, the deteriorating patient policy was out of date. It was developed by the previous organisation that the staff worked for and had expired in November 2018. Staff recorded all initial assessments, treatment plans, x-rays needed and results, the need for review by a senior health professional and signposting and referral to other agencies. Healthcare professionals were aware of red flag symptoms and acted appropriately in all cases.

The Walk in Centre and Minor Injury Unit had a business continuity plan for emergency situations this was approved in October 2018. There was a detailed plan and action cards found in the on-call folders at four various locations across the trust. There was not one found at the Haywood Hospital or Leek Moorlands Hospital for urgent care staff to be able to access. The trust told us that there was a basic plan minus action cards at all the locations.

Staffing

The service did not have enough nursing staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment.

There was a discrepancy between planned and actual staffing. We saw staffing rotas that showed there was a discrepancy between staff planned to cover shifts and actual staff during the inspection. The trust also supplied us with staffing rotas for the period 27 January 2019 to 23 March 2019. This showed the percentage of shifts that were unfilled. This included 20% for nurse prescribers, 38% for full support workers and 27% for administrative staff. The e-rostering system

had a range of predetermined rules identifying the shift pattern needed, together with the number of staff and grades required on each.

The system then generated an unfilled duties list based on the shortfall between the required staff and those identified in the table below. This list of unfulfilled duties then goes to the Trust temporary staffing team to source bank cover for these.

	Total		
	Unfilled Duties	**Total Shifts**	**% Unfilled**
Nurse Prescriber	128	645	20%
HCSW	58	154	38%
A&C	53	197.5	27%

In addition, the tables below show the position as at 31 March 2018 and the preceding six months. This also shows an unfilled shifts percentage of between 23% and 21%.

Year 1 section (previous financial year):

Details of staffing levels within community urgent care services by staff group as at 31 March 2018 are below.

Community urgent care total

Staff group	**Planned staff WTE**	**Actual Staff WTE**	**Staffing rate (%)**
Qualified nursing & health visiting staff (Qualified nurses)	26.07	18.96	72.7%
Support to doctors and nursing staff	14.75	12.39	84.0%
Total	40.82	31.30	**76.8%**

Year 2 section (current financial year so far):

Details of staffing levels within community urgent care services by staff group as at 30 September 2018 are below.

Community urgent care total

Staff group	**Planned staff WTE**	**Actual Staff WTE**	**Staffing rate (%)**
Qualified nursing & health visiting staff (Qualified nurses)	25.37	19.56	77.1%
Support to doctors and nursing staff	15.74	12.79	81.2%
Total	41.1	32.3	**78.7**

The staffing establishment was inadequate. In addition to the problem of unfilled shifts, managers were not happy with the staffing establishment and felt that there should be more staff. The service had a shortfall of over 20% in the last 18 months. Managers could show us their establishment figures and told us that they had inherited the staffing levels from the previous organisation and were now reviewing what the establishment should be.

The vacancy rates for nursing staff was high. The managers confirmed the vacancy rates for qualified nursing staff. They told us that they could not attract recruitment to Leek minor injuries unit due to the current consultation about services at Leek Moorlands Hospital.
The trust set a target of 8% - 12% for vacancy rates. From October 2017 to September 2018, the trust reported an overall vacancy rate of 21% in community urgent care services. This did not meet the trust's target. Across the service overall vacancy rates for nursing staff were 23%.

A breakdown of vacancy rates by staff group in community urgent care services at trust level and by team/site is below:

Community urgent care total

Staff group	**Establishment**	**Vacancies**	**Vacancy rate (%)**

Qualified nursing & health visiting staff (Qualified nurses)	25.4	5.8	23%
Support to doctors and nursing staff	15.7	3.0	19%
All staff	41.1	8.8	21%

Nursing staff by site

Site name	Establishment	Vacancies	Vacancy rate (%)
Leek Moorlands Hospital	6.3	2.3	37%
Haywood Hospital	19.1	3.5	18%
Total	25.4	5.8	23%

The vacancy rate was highest at Leek minor injuries unit but was still an issue at the Haywood walk in centre. Staff told us that banding of the advanced nurse practitioner role may contribute to the high vacancy rate. The role was a band 6, and in many other units across the country was a band 7. Staff at the Haywood walk in centre told us there were four qualified nurses on the day of inspection when there should have been five and estimated that this happened 50% of the time.

Staff we spoke with said the trust expected walk in centre staff to work in other departments. The trust used healthcare support workers from Leek minor injuries unit to cover the hospital reception between 5 and 8 PM. At times, this affected patient care as staffing was already an issue. Managers had raised this issue and they had obtained support to change this.

Staff turnover rates at Leek minor injuries unit were high. Managers told us that turnover rates at Leek Moorlands Hospital were high due to the uncertainty of long-term employment as the hospital was going through a consultation process.

The trust set a target of 10%-15% for staff turnover rates. From October 2017 to September 2018, the core service reported an overall turnover rate of 11% in community urgent care services. This met the trust's target. Across the core service, overall turnover rates for nursing staff were 15%.

A breakdown of turnover rates by staff group in community urgent care services at core service level and by team/site for the year ending September 2018 is below:

Community urgent care total

Staff group	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Qualified nursing & health visiting staff (Qualified nurses)	19.6	2.8	15%
Support to doctors and nursing staff	12.8	0.6	5%
Grand Total	32.3	3.4	11%

Nursing staff by site

Site name	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Leek Moorlands Hospital	3.9	1.0	27%
Haywood Hospital	15.6	1.8	13%
Grand Total	19.6	2.8	15%

The sickness rates across both units was low. The trust set a target of 4.8% for sickness rates. From October 2018 to September 2018, the trust reported an overall sickness rate of 0.7% in community urgent care services. This met the trust's target. Across the trust overall sickness rates for nursing staff were 0.1%.

A breakdown of sickness rates by staff group in community urgent care services at core service level and by team/site for the year ending September 2018 is below:

Community urgent care total

Staff group	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Qualified nursing & health visiting staff (Qualified nurses)	6636.88	6.85	0.1%
Support to doctors and nursing staff	4523.13	67.25	1.5%
Total	**11160.01**	**74.11**	**0.7%**

Nursing staff by site

Site name	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Leek Moorlands Hospital	1378.80	3.85	0.3%
Haywood Hospital	5258.08	3.00	0.1%
Grand Total	**6636.88**	**6.85**	**0.1%**

Qualified nursing bank staff were used to manage the shortfall in shifts due to vacancy rates. Managers and staff told us that they preferred to use their own qualified staff to carry out extra shifts due to the high level of skill needed for qualified nursing in the urgent care departments.

From October 2017 to September 2018, of the 50347 total working hours available, 1% were filled by bank staff and less than 1% were covered by agency 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, less than 1% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Haywood Walk-in Centre	37378	56	<1%	8	<1%	15	<1%
Leek Hosp Minor Injuries	12968	244	2%	0	0%	45	<1%
Core service total	**50347**	**299**	**1%**	**8**	**<1%**	**60**	**<1%**

Bank staff was sometimes used to manage the vacancies and ensure shifts were filled. Managers told us that they try to use bank rather than agency staff because they needed people with emergency care skills to work in the departments. They said that it was difficult to obtain agency staff with the correct skills.

From October 2017 to September 2018, of the 29685 total working hours available, less than 1% were filled by bank staff and none were covered by agency staff to cover sickness, absence, or vacancy for qualified nurses.

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

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Haywood Walk in Centre	22316	19	<1%	0	0%	0	0%
Leek Hosp Minor Injuries	7370	0	0%	0	0%	0	0%

Core service total	**29685**	**19**	**<1%**	**0**	**0%**	**0**	**0%**

. During the reporting period from October 2017 to September 2018, community urgent care services reported that there were no cases where staff have been either suspended or placed under supervision.

Quality of records

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

There were electronic patient records that all staff recorded their interactions with patients in. We reviewed 17 sets of electronic patient records. We reviewed 10 sets at Leek minor injuries unit and seven sets at the Haywood walk in centre. All staff could access records for patients attending both units as they were stored on the same electronic system. Staff had completed the records accurately, fully, and in all cases. We could see the times that patients had arrived, were assessed, treated, and discharged in all cases. We could clearly see which member of staff had carried out what care for each patient. Staff completed records at the time of seeing the patient.

We saw that where staff referred patients for x-rays, they completed the referral request in all cases, alongside the x-ray results and the follow-up actions and treatments. Where patients met the child protection information system criteria, staff had completed this fully. Staff took consent and recorded this where appropriate.

Medicines

The service followed best practice when prescribing, giving, recording, and storing medicines. Patients received the right medication at the right dose at the right time.

The service had safe and effective prescribing methods. The service used patient group directions (PGDs) to ensure staff could provide patients with medication promptly. We reviewed 19 patient group directions (PGDs). The patient group directions (PGDs) had all been reviewed and approved. Some were still recorded as being patient group directions (PGDs) under the previous organisation, however there was a new patient group directions (PGDS) available for use. The service audited the PGDs and we saw they last audited them on 12 December 2018. Staff attended training to use PGDs. The service supported staff to become non-medical prescribers.

The service recorded and stored medicines in accordance with best practice. Staff ensured emergency medication was available and up-to-date in all cases. We reviewed records over a six-week period. Staff stored medicines in secure cabinets with key pad access, in a locked room. The nurse in charge held the keys to the locked room. Staff checked ambient room temperatures and medication fridge temperatures daily. We reviewed records over a four-month period. They kept a record of the checks, any issues, and actions. Staff recorded allergies in the patient record in all relevant records.

Whilst onsite we reviewed the standard operating procedure for the administration of adrenaline it was out of date in August 2018. However, the trust provided evidence that the incorrect standard operating procedure had been provided onsite and the current one had an initial review date of December 2018 and was extended to June 2019.

Incident reporting, learning and improvement

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no never events in community urgent care services.

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community urgent care services, which met the reporting criteria, set by NHS England, between October 2017 to September 2018.

The service did not always manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents but did not share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service used an electronic incident reporting system and all staff knew how to use the system. Staff showed us the incident reporting system and explained how they would complete an incident form.

The service reported 18 incidents between 1 September 2018 and 28 February 2019. There were six near misses, eight no harm, four minimum harm, zero moderate harm and zero severe harm during this period.

Of the six near misses, four of those were about other services. One incident related to not recognising a deteriorating patient and the other was relating to low staffing levels.

Of the eight no harm incidents, three were related to unsafe staffing, where the unit had to be closed on two of these occasions, one was in relation to a medication issue made due to low staffing, two were due to lack of sterile equipment for carrying out procedures, and two related to other services.

Of the four minimum harm incidents three related to poor care. Two of these were about patients who did not receive adequate pain relief even though they were in intense pain, and the other one was to do with referral to an incorrect care facility. The other incident related to other services.

The service did not have a system where they shared learning from incidents across the two units. Managers gave specific feedback to individual team members if they were involved in an incident, either face-to-face or by email.

Is this service effective?

Evidence-based care and treatment

The service supplied care and treatment based on national guidance but could not provide evidence of its effectiveness. Managers did not check to make sure staff followed guidance.

The service used National Institute of Care Excellence (NICE) guidance. Staff had access to an app on the clinical dashboard with a link to National Institute of Care Excellence (NICE) guidance. They followed National Institute of Care Excellence (NICE) guidance for antimicrobial prescribing, (the prescribing of antibiotics for infection).

Staff have access to a handbook, which covered a range of locally approved clinical protocols. The handbook guided assessment and was review.

Managers did not have a system of audit to check the use of evidence-based care. Because managers told us they did not have a current clinical audit programme, they could not be assured staff were following guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

The trust provided patients with access to a cafeteria at the Haywood walk in centre. The service supplied water coolers and vending machines for snacks and hot drinks at both units. These were in good working order.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain. They supported some of those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. The Royal College of Emergency Medicine (RCEM) states that all children to be offered pain relief within 20 minutes of arrival and those in severe pain be reassessed every hour. The Royal College of Emergency Medicine (RCEM) best practice guideline states that all people of all ages should have their pain assessed at the point of triage. Anyone in moderate or severe pain should receive pain relief within 20 minutes.

Pain relief was delayed in some cases due to the lack of a triage system. Staff gave pain relief quickly to those patients who met the red flag criteria that the receptionist used. But for the patients that did not meet the receptionists' urgent criteria, staff did not give pain relief until they had their initial assessment.

The service sometimes used supportive tools to ask about pain. The service used a smiley faces tool to assess pain in children. The service used language line to support patients whose first language is not English to assess pain. They did not have supportive tools to assess pain for people with disabilities.

Staff recorded that they had given analgesia at the initial assessment and we saw them asking the patients.

Patient outcomes

Managers did not monitor the effectiveness of care and treatment and therefore did not use findings to improve them. They did not compare local results with those of other services to learn from them.

The trust did not participate in any clinical audits in relation to this core service as part of their Clinical Audit Programme.

The managers said they did not take part in an audit program to monitor patient outcomes, but this was planned.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised most of the staff's work performance but did not hold supervision meetings with them to give support and check the effectiveness of the service.

Staff were skilled and knowledgeable about minor injury and minor illness. We saw staff delivering care for patients. They were skilled and knowledgeable about the minor injury or illness the patient had. The service supported staff to access additional training, such as specialist clinical subjects.

Staff were competent medication prescribers. The trust supported non-medical prescribers with training and a network of mentors and feedback.

The service did not support staff through structured clinical supervision. Managers and staff at Leek minor injuries unit told us that there was informal supervision, where staff supported each other, especially if there had been a problem they felt they needed to talk about. Staff said they did not have any clinical supervision meetings.

The service could not provide evidence that monthly staff clinical supervision was being undertaken as per their policy. It meant managers were unable to demonstrate how they had managed the impact of incidents and discussed lessons learnt with individual staff members.

From April 2018 to November 2018, 76% of permanent non-medical staff within the community urgent care services core service had received an appraisal compared to the trust target of 90%.

Community urgent care total

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Support to doctors and nursing staff	11	14	79%	90%	No
Qualified nursing & health visiting staff (Qualified nurses)	20	27	74%	90%	No
All staff	**31**	**41**	**76%**	**90%**	

Nursing staff by site / location

Site or location	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Haywood Hospital	16	21	76%	90%	No
Leek Moorlands Hospital	4	6	67%	90%	No
Total	**20**	**27**	**74%**	**90%**	

Not all staff had an annual appraisal. Managers supplied appraisals for two thirds of staff. We spoke with managers and staff about the appraisal rates the trust supplied. The managers told us that most staff had their appraisal this year, and they had worked hard to ensure staff received them. Some of the staff we spoke to said they had an appraisal in the last 12 months. Managers raised the issue of appraisal rates at their monthly management meetings.

Multidisciplinary working and coordinated care pathways

Staff of various kinds worked together as a team to help patients. Nurses, and other healthcare professionals supported each other to supply good care.

The staff in the units worked well together. We saw receptionists, qualified nurses and healthcare support workers working together efficiently at both units, to deliver good care for patients.

The walk in centre and minor injuries unit had good relationships with the x-ray departments at both sites. The x-ray departments prioritised patients from the units because they had urgent minor illness or injuries.

The service had a clear pathway for patients needing urgent treatment at an emergency department. They also had direct referral to the local fracture clinic so that the patient could go home with their appointment already arranged.

There was effective communication with the patients GP. The walk in centre and minor injuries units wrote to the patients GP and they put this onto the electronic system. This ensured the patients GP got the letter quickly. The letters had complete information about the patient's visit, including assessment, tests, treatment, and what the patient should do to aid recovery.

We saw examples where staff at both units contacted the patient's GP and other healthcare professionals for more information to ensure they had all the information necessary to treat a patient.

The service accessed support from mental health teams, they knew who they were and how to contact them for any patients that needed an urgent assessment in the unit.

All staff could make referrals to the rapid assessment interface discharge (RAID) team.

Staff at the units ensured patients were referred and signposted to other departments effectively, such as the health visiting team for children. It was not clear whether the service signposted to substance misuse support services.

Health promotion

The service and staff used opportunities to promote good health for patients. We saw health promotion posters around both units that were easily accessible for patients. We looked at records and saw that staff gave information during assessments of patients about health promotion. They told people about how to access smoking cessation services, information about prevention of falls and prevention of accidents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

We saw consent recorded in patient records by parents and carers where the patient was unable to give consent themselves.

Staff could tell us about capacity and had awareness of the mental capacity act.

The trust set a target of 90% for completion of Mental Capacity Act / deprivation of liberty standards training.

From 1 April 2018 to 30 November 2018 the trust reported that Mental Capacity Act (MCA) training had been completed by 97% of staff within community urgent care services. The Trust's Mental Capacity Act training covers all aspects of the act including deprivation of liberty safeguards (DoLS).

A breakdown of compliance for MCA courses from 1 April 2018 to 30 November 2018 for nursing and midwifery staff in community urgent care services is shown below:

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Mental Capacity Act Level 2	28	29	97%	90%	Yes

Staff told us they had completed their training and were able to describe the mental capacity act and how it would be used in the units.

We saw staff taking consent and saw consent recorded in the patients' records.

Is this service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Receptionists and nursing staff treated patients with kindness. We spoke with 14 patients who all said staff treated them with respect and dignity. They said that staff provided a good and skilled

service. Patient spoke very highly of the nursing staff and used words such as 'amazing' and 'brilliant'. We saw staff talking with patients in a kind way and acting in a caring manner.

Staff always kept the privacy of patients when undergoing examination. Staff ensured they closed doors when they took patients into the rooms for consultation or treatment.

Patients gave feedback that was mainly positive. For patients that attended the Haywood walk in centre and completed the friends and family test for the period 1 April 2018 to 31 March 2019, 87% said that they would recommend the service to friends and family. Patients that attended the Leek minor injuries unit and completed the friends and family test 98% said they would recommend the service to friends and family. For patients who attended the Haywood walk in centre, 92% said they were satisfied with the quality of care. All the patients that attended Leek minor injuries unit that completed the friends and family test said they were satisfied with the quality of care they received.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff tried to minimise distress. We saw reception staff tell patients that nursing staff would see them as soon as possible, and we saw all staff show empathy when dealing with patients in pain or who were feeling unwell.

Some patients were distressed because of waiting times. Some of the patients we spoke to expressed concern at the length of waiting times and said they felt stressed because of this.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment but did not always supply enough information.

Staff always explained treatment and referrals to patients. The patients we spoke to said that staff explained their treatment clearly and gave them clear verbal information.

Staff supported patients whose first language was not English. We saw a patient whose first language was not English, and the staff supplied translation services immediately to ensure the patient could understand instructions they were giving them.

For the patients who attended the Haywood walk in centre and completed the friends and family test, 95% said that they were listened to by staff, 84% said that they felt they were involved in decisions about their care and treatment and 76% said they had enough information about their care and treatment. All the patients who attended Leek minor injuries unit and completed the friends and family test said that they were listened to by staff, 93% said that they felt they were involved in decisions about their care and treatment and 70% said they had enough information about their care and treatment.

Is this service responsive?

Planning and delivering services which meet people's needs

The trust planned and provided services in a way that met the needs of local people.

The trust provided services at two sites to ensure people living in areas that are more rural had a local service that they could access. Leek is a rural town that is 10 miles away from the Haywood walk in centre. This meant that people did not have to travel long distances to access minor injury and minor illness services.

The trust provided the main service at a central location. The Haywood walk in centre was a central location for people living in the northern Stoke-on-Trent area. The hospital was located on the main bus route out of the city centre.

People could access x-ray facilities easily. Both units supplied x-ray facilities to support patients obtaining tests at the time they needed them and did not have to travel to another centre or hospital to get them. This was particularly good at Leek minor injuries unit as this was in a rural area which was several miles away from the main hospital centre.

Patients had direct access to specialist ophthalmologists. Staff could refer patients with urgent eye problems directly to two local ophthalmologists. Patients could go directly to the ophthalmologists and be seen straightaway.

Both units could refer patients directly to the emergency department at the local acute hospital if their injury or illness was more serious than those the units could deal with. For example, if a patient had sustained a complex fracture, the healthcare professional could refer directly to the correct team for this at the emergency department.

There was mixed provision of waiting areas. The waiting area at the Haywood walk in centre was sufficient to ensure there was enough seating for people who were waiting. However, the waiting area at Leek minor injuries unit was limited.

There were enough signs at both units so that people knew where to go. There was information about waiting times at all the local urgent care centres. This was a live system that was updated regularly.

Meeting the needs of people in vulnerable circumstances

The service took account of some patients' individual needs.

The information for patients' GPs was particularly good. This meant the GP could access this very quickly and had enough information to meet individual needs. We saw staff giving information to patients about their discharge from the unit. We saw the discharge letters to the GP that recorded in the electronic patient record. There was advice on pain relief, antibiotics and other treatments, referral to other departments and hospitals and what to do if things went wrong.

The service had developed a guide for the completion of the child protection check. Staff showed us the checklist they had developed for their service to ensure they carried out a child protection check on any patient 0 to 19 years of age, or an expectant mother. The guide was step-by-step instructions to ensure all staff followed the procedure correctly.

Staff supplied information on waiting times using a TV screen in the waiting area. This included the expected current waiting time for staff to see patients and the number of patients currently in the department. They also included information on alternative local services that may have been able to offer a shorter waiting time. However, wait times were dependent on the time of arrival at the unit and not the urgency of need in the absence of a triage system.

Patients could also access web-based application that gave them information on waiting times at all local urgent care and emergency department services.

Staff knew how to support people whose first language was not English during consultations and treatment but did not supply enough written information. Staff could describe how to use language line to ensure translation services were available for those whose first language was not English. There was a range of leaflets however these were only in English. We did not see any signposting to information in other languages. We saw a specific leaflet about Leek minor injuries unit which described the service that patients would receive, in English only.

The service had links with mental health services for people who needed them. The service had an agreement with the local mental health trust that provided people with urgent mental health support 24 hours a day. This service was the rapid assessment, intervention, and discharge (RAID) team. Staff knew how to contact the team to access support for people.

Children did not always have their individual needs met at the units. There was no separate waiting area for children at both units, and no quiet areas to wait for people who were distressed by a noisy environment. The waiting area at the Haywood walk in centre was very busy and children with injuries were waiting alongside adult patients. The waiting area at Leek minor injuries unit was exceedingly small and we saw children waiting alongside patients who appeared very unwell. Staff did their best to alleviate distress of children, however the waiting area did not provide a calming environment for children. Staff said that they would take patients with acute mental health problems into a private room while they contacted urgent mental health services.

The largest ethnic minority group within the trust catchment area was Asian/Asian British with 12% of the population.

	Ethnic minority group	**Percentage of catchment population**
First largest	Asian/Asian British	12.3%
Second largest	White Other	8.0%
Third largest	Mix heritage	4.3%
Fourth largest	Black/Black British	2.7%

The service did not meet accessible information standards. People with communication issues did not have their individual needs met at the units. The Accessible Information Standard says that all publicly funded adult social care and health providers, including GPs, hospitals, and care provided by social care services, must identify and meet the information and communication needs of those who use their services and have communication difficulties because of a disability or health problem. The service did not have any communication tools for people with disabilities, for example learning disabilities or impaired sight. Staff said that people with learning disabilities usually attended the department with a carer or relative who would communicate with them. The trust supplied information after the inspection about resources that staff could access to support people with learning disabilities. Staff could access websites containing easy read resources, they could look at guidance information about learning disabilities passports and they could order hospital communications books. However, these websites did not provide communication tools that could be accessed and printed off at the time of the patients attending the unit. The trust told us that staff could access easy read health leaflets for patients with learning disabilities, however staff were not aware of this when we asked.

Access to the right care at the right time

People could access the service when they needed it. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice. The service did not triage patients within 15 minutes of arrival.

We raised the lack of triage with the service managers and they responded quickly with several interventions.

After further discussion managers said they recognised that they needed a triage system. They told us they would review their red flag system, staff training, and would review the triage system at the local acute hospital to aid a review of their own procedures. Following the inspection, the service implemented a triage system at both units. They informed patients attending both units that this was now in place and that they aimed to see patients within 15 minutes of arrival for a brief check by a healthcare professional. Patients would then be safe to wait and would be signposted to other services as needed.

The service mostly saw patients within one hour of attending the department. The Royal College of Emergency Medicine (RCEM) guidelines state that people should receive treatment within an hour of attending the department. We reviewed 10 sets of patient records at Leek minor injuries unit which showed that a healthcare professional had assessed 8/10 people within an hour. We reviewed seven sets of patient records at the Haywood walk in centre which showed that healthcare professional had seen all seven patients within an hour. We spoke with 11 patients and

10 could tell us how long they had waited to be seen. One patient was seen at once and sent to the emergency department, nine patients said they had been seen between 40 minutes and an hour and one patient said they had waited for two hours.

The service had an effective full capacity protocol. Managers provided us with their standard operating procedure for the Haywood walk in centre capacity. They had identified the potential for excessive demand near to closing time. Managers developed a tool for assessing staffing levels against patient numbers at 7:30pm, followed by a formal service status review at 8pm with relevant actions. They carried out a further service status formal review at 9pm with relevant actions.

The service did not collect data about referral to treatment times. The trust did not provide information about community urgent care services on referral time to assessment or treatment. We asked the trust for audits about referral waiting times in the department, they told us that they did not have a system in place to monitor how long people wait to be seen at the units. However, they would be looking at this in the future. The service supplied information that showed monitoring referral to treatment time was now on the service risk register.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them but had not learned lessons from the results, and shared these with all staff.

The service did not always respond to complaints in a timely way. From 1 October 2017 to 30 September 2018 there were four complaints about community urgent care services. The trust took an average of 65 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 35 (Staffordshire and Stoke-on-Trent partnership trust) or 25 (South Staffordshire and Shropshire Healthcare NHS Foundation Trust) working days.

Managers told us that they responded to complaints on time. They said that it took less than 65 days to respond to complaints and could not understand the information the trust had supplied us with.

The service did not have a forum to share complaints with staff. Staff said that managers would speak to individuals who were involved in the complaints, but they did not discuss complaints at any meetings, and therefore had no way of sharing learning across the units.

<u>The community urgent care services</u>

Subject	Number of complaints
Clinical treatment	2
Access to Treatment or Drugs	1
Trust Admin/Policies/Procedures Including Patient	1
Total	4

The service received complaints about four diverse types of issues. There was no theme to the complaints. Two of the complaints were not upheld, one was withdrawn, and one was upheld. None of the complaints were referred to the ombudsman.

Managers received three complaints about the Haywood walk in centre from 1 October 2017 to 30 September 2018. One of these was about access to treatment, a second was about failure to diagnose and the third was about failure of the service to follow its own procedures. The service investigated the first two complaints. The service took 120 days from receipt of the complaint to the final closure of the complaint and it took 67 days to complete the second complaint. The service negotiated extension to timescales with the complainants, due to difficulties completing actions some of which were beyond the services control. Both complaints were not upheld. The third complaint was withdrawn because the service did not receive consent from the complainant to take things forward.

Subject	Number of complaints
Access to Treatment or Drugs	1
Trust Admin/Policies/Procedures Including Patient	1
Clinical Treatment	1
Total	**3**

Community urgent care – Leek Moorlands Hospital

Subject	Number of complaints
Clinical Treatment	1
Total	1

Managers received one complaint about the Leek minor injuries unit from 1 October 2017 to 30 September 2018. This complaint was made about treatment in relation to an infection. The complaint was investigated, and the service took 38 days to complete the complaint with managers updating the complainant regularly. The complaint was upheld.

The service received many compliments from patients and families.

From 1 October 2017 to 30 September 2018 the trust received 10971 compliments. Of these, 134 related to community urgent care services, which accounted for 1% of all compliments received by the trust.

Team	Number of compliments
Minor Injuries / Walk in Centre	134
Total	

Managers made staff aware of individual compliments they had received. Managers photocopied compliments and they gave a copy to individual staff members for them to keep. Thank-you cards were displayed in the units.

Is this service well-led?

Leadership

Managers at all levels in the service did not always have the right skills and abilities to run a service providing high-quality sustainable care, and the leadership team was new.

A service manager and a consultant nurse led the service. The service manager post had been in place since January 2019. This was a new post created to support the consultant nurse, who had previously been managing the service, as well as supplying clinical leadership. The service manager and consultant nurse worked closely together to lead the service. The leaders told us the interview process was based on a competency framework for managers. Staff said they were concerned that they saw less of the consultant nurse and felt that because the professional background of the service manager was not nursing, they could not always give the support they needed.

The leaders were unsure of the need to have a 15-minute triage system for a high-quality service. We saw that a 15-minute triage system was not in place and spoke with managers about this. Initially they felt that this was not appropriate as they were not an emergency department. Royal College of Emergency Medicine (RCEM) best practice guideline-Initial assessment of emergency department patients (2017) states that patient should be assessed by qualified healthcare professional within 15 minutes of arrival. The managers responded quickly to rectify this problem.

Senior managers did not always support the service leaders. The service leaders did not have formal one-to-one meetings with their own line managers. Senior managers did not attend

meetings at Leek minor injuries unit. Staff said they had met the chief executive once, but they did not see other managers visit the service.

Staff felt well supported by the leadership team. Staff said that they could approach both the service manager and consultant nurse with any issues they had and felt they would be listened to. They said that they obtained clinical support from the consultant nurse but felt that their availability was less since the new leadership arrangement was put in place. A senior nurse was available to support staff when the usual leadership team were not there, such as at weekends or late evenings.

Vision and strategy

The trust had a clear vision. We saw posters about the trust vision and on their intranet. Managers and staff were aware of the trust vision.

The service did not have a strategy. Managers told us that they had ideas for the future to develop the service. They gave an example of streaming, they were aware that patients were waiting and felt they could improve this by streaming people presenting with minor injuries and minor illness. They felt that there were some patients who could be signposted to other services at the point of triage and this would reduce waiting times. Managers were aware of the local consultation processes about the development of care hubs. The care hubs will involve delivery of many services including urgent care across North Staffordshire. They felt it was difficult to work on a strategy until the consultation process was complete and they had direction from the clinical commissioning group.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was a positive culture at both units. Staff said they were happy in their work and had close working relationships with one another. They said they could go to their peers for any support. Staff said they felt proud of their work. Staff at Leek minor injuries unit said they felt good about the fact they could see people in a rural location quickly without the need to go and access services that was some distance away.

Some staff did not feel valued. They felt there was a discrepancy between banding of their roles in the service they worked in and banding across the country. They felt they carried out the same role as others in the band higher than themselves and that this was unfair.

Governance

The trust did not use a systematic approach to continually improve the quality of its service and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust provided information about their governance framework. This showed that there should be local team meetings, local governance meetings and daily safety huddles within the units. Service leads attended hospital management team meetings but did not escalate service specific issues at this forum. The nurse consultant, service lead and unit manager at Leek minor injuries unit attended on a regular basis. The trust supplied us with four months' worth of meeting minutes between November 2018 and February 2019 which showed their attendance, and that urgent care issues were rarely discussed. Most of the meeting agenda considered generic hospital wide issues and urgent care services did not offer a routine escalation report to this meeting. The trust has now put in place the requirement for this to be implemented for subsequent meetings and has implemented safety huddles within the unit to monitor risk.

Management of risk, issues and performance

The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were no risks for urgent care recorded on the trust's corporate risk register. Managers of the service told us that they were aware of the corporate risk register and that this was discussed at the management meetings they attended. They told us that staffing levels were a risk at Leek minor injuries unit due to the current consultation about whether services were still going to be delivered from there. The trust supplied their risk register, which showed there were no risks recorded even though staffing, mandatory training, manual handling, and the potential relocation of services in Leek were known to be an issue.

The trust supplied us with their latest corporate risk register and associated minutes of the hospital management meeting which showed risks between November 2018 and February 2019. There were no risks recorded for urgent care.

Information management

The trust used secure electronic systems with security safeguards but did not collect information and did not analyse it to support activities.

The service did not analyse incident reporting against staff shortages.

There was a discrepancy between unfilled shifts and incident reports for the period between 1 September 2018 and 28 February 2019. During this time there were four incidents reported due to staff shortages however the trust supplied information that showed approximately 20% of shifts went unfulfilled. The trust knew that staffing shortages should be incident reported in instances where staff feel that the arrangements put in place for short notice shortfalls (i.e. sickness) are not adequate. They could not explain the difference between staff disclosure and the incident data. They said that they would explore the issue of staff reporting these issues via the incident reporting system where they feel safe staffing levels were not achieved.

The service did not collect information from the electronic patient record to improve services. The service leads said there was not any audit programs relating to the improvement of patient care using the electronic patient record system they had in place.

The service used a validated, secure electronic patient record system. Both units use the same system as each other which was also linked to the system used at the local emergency department. All staff recorded the patient information taken from the time of booking in at reception to leaving the department in a single system. This system recorded several auditable records, including referral to treatment times, diagnoses, recording of allergies, patient demographics.

Engagement

The service did not always engage well with patients and staff. They consulted public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

There was limited use of the friends and family test. Staff on the unit were aware of the friends and family test however they did not promote it to obtain patient feedback. Staff told us that the feedback forms were in reception, but they did not actively engage with patients to complete them. The friends and family test which was carried out between 1 April 2018 and 31 March 2019 showed 47 respondents from Leek minor injuries unit and 90 respondents from the Haywood walk in centre. Managers told us that there were between 125 to 200 people attended the units every day, this equates to an average total of 56,000 per year. This means that for both units less than 0.25% of people completed the friends and family form in a year.

The service did not have a programme of team meetings for both units. Staff said that they had not had regular team meetings to discuss incidents complaints and their learning. Managers and staff

told us that a team meeting had recently been set up for Saturday morning for all staff to attend. The service held regular handovers that covered clinical issues, however there was no evidence that regular minuted team meetings took place on either unit. Following the inspection, the trust told us that the unit had implemented regular morning 'Huddles' as per the trust quality improvement guidance.

Staff said managers kept them up to date with trust information. Staff had been kept informed about the change that they went through recently when they were taken over by Midlands Partnership Foundation Trust from their previous employer. Managers also kept staff informed of other trust and service information via email. However, we were unable to see clear communication channels for the sharing of information.

The trust was now consulting on development of health services across North Staffordshire which included urgent care services. Managers told us about the consultation process and how local people could be involved. There was a consultation website where members of the public could vote. On the website there was a box to click called "have your say ". The trust was working with the local clinical commissioning groups to shape the future of services for Northern Staffordshire.

Learning, continuous improvement and innovation

The trust had a proposal to extend physiotherapy assessment into the Haywood walk in centre for musculoskeletal (MSK) conditions. The Midlands Partnership Foundation NHS Trust supplied a Musculoskeletal Interface Service that was based at the Haywood Hospital. This was an out-patient service that a consultant physiotherapist and rheumatologist led with most of the patients being assessed, diagnosed, and treated by extended scope practitioners (physiotherapists). The proposal is to base one of the extended scope practitioners in the walk-in centre as an initial pilot so that they can identify appropriate patients following triage with likely MSK problems to assess, diagnose and treat.

Mental health services

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
The Redwoods Centre	Birch Redwoods	16	Mixed
The Redwoods Centre	Laurel Redwoods	16	Male
The Redwoods Centre	Pine Redwoods	16	Female
George Bryan Centre	George Bryan West Wing Tamworth (closed Feb 2019)	20	Mixed
St George's Hospital	Brocton Stafford	20	Mixed
St George's Hospital	Chebsey Stafford	19	Mixed
St George's Hospital	Norbury Stafford	11	Male
St George's Hospital	Milford Stafford (since Feb 2019)	12	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 this service safe?

Safe and clean environment

Safety of the ward layout

Staff ensured the environment was safe. Staff did regular risk assessments of the care environment. However, Chebsey and Brocton had two different anti-barricade door systems and staff in Brocton were not able to operate the other system in communal areas. Staff could operate the system on the bedroom doors. One agency staff member on duty in Chebsey did not know how the anti-barricade system worked. This could potentially delay the response of staff to a patient emergency. The manager immediately contacted estates to sort out the issue and the use of the anti-barricade system was put on the induction checklist.

The layout of all the wards enabled staff to observe most of the parts effectively from the corridors. Staff were present in the corridors and had clear lines of sight of all bedrooms within that corridor. Only Milford had blind spots when approaching the kitchen and dining room areas. All blind spots were well managed by mirrors.

Over the 12-month period from 1 October 2017 to 30 September 2018 there were no mixed sex accommodation breaches within this service.

In our focused inspection in September 2017 we told the trust that they must safely manage the risks of sexual safety in mixed gender wards in line with the Department of Health guidance. We found that improvements had been made. Norbury, Pine and Laurel wards were single gender wards. The wards complied with guidance on eliminating mixed-sex accommodation. All other wards had distinct male and female sleeping areas and a designated female lounge. Brocton ward had a separate corridor with mixed gender for Ministry of Defence personnel, with six bedrooms that had ensuite facilities.

There were ligature risks on all wards within this service. All wards have had a ligature risk assessment in the last 12 months (between 1 October 2017 and 30 September 2018).

Ward / unit name	High level of risk? Yes/ No	Summary of actions taken
Birch	No	Mitigation plan completed. Staff observations and engagement form this plan, and control measures are put in place as required. The mitigation plan allows the ward to manage the risks locally.
Brocton	No	Mitigation plan completed. Staff observations and engagement form this plan, and control measures are put in place as required. The mitigation plan allows the ward to manage the risks locally.
Chebsey	No	Mitigation plan completed. Staff observations and engagement form this plan, and control measures are put in place as required. The mitigation plan allows the ward to manage the risks locally.
Laurel	No	Mitigation plan completed. Staff observations and engagement form part of this plan and control measures are put in place as required. Remedial works have been identified as part of a schedule of works to reduce risks further and allow the ward to manage the risks locally.
Norbury	No	Mitigation plan completed. Staff observations and engagement form this plan, and control measures are put in place as required. The mitigation plan allows the ward to manage the risks locally.
Pine	No	Mitigation plan completed. Staff observations and engagement form part of this plan and control measures are put in place as required. Remedial works have been identified as part of a schedule of works to reduce risks further and allow the ward to manage the risks locally.
West Wing	No	Mitigation plan completed. Staff observations and engagement form part of this plan and control measures are put in place as required. Remedial works have been identified as part of a schedule of works to reduce risks further and allow the ward to manage the risks locally.
Milford	No	Mitigation plan completed. Staff observations and engagement form part of this plan and control measures are put in place as required. Remedial works have been identified as part of a schedule of works to reduce risks further and allow the ward to manage the risks locally.

The trust had undertaken ligature risk assessments at all locations. Two of the wards had potential ligature points in areas where patients had unsupervised access, presenting a ligature risk. The trust could not give us the time frames on the plan to eliminate the ligature points. They told us that the taps were used to manage the risk of legionella that had been identified in the water system. The other wards had all anti-ligature fittings and furniture in all high-risk areas which lowered the level of ligature risk.

All the wards had detailed up-to-date ligature risk assessments which identified the ligature points. The wards had risk management plans on how to minimise ligature risk to patients. Control measures included individual patient risk assessments, use of observations, staff supervision and locked areas.

The wards had alarm systems that helped to ensure the safety of patients and staff. All staff had easy access to personal safety alarms and all patients' bedrooms were fitted with nurse call systems.

Maintenance, cleanliness and infection control

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the locations scored higher than similar trusts for cleanliness and for condition, appearance and maintenance.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	99.6%	99.3%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units Wards for older people with mental health problems	100.0%	99.4%
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	99.5%	99.3%
Trust overall		**99.6%**	**99.3%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

There was a good standard of cleanliness in all wards. All areas were very clean, had good furnishings and décor, and were well-maintained.

Staff maintained and recorded cleaning routines as scheduled. Cleaning records were up to date and demonstrated that all ward areas were cleaned regularly.

Staff followed good infection control principles and procedures. Staff used alcohol gel and practiced hand washing hygiene, food hygiene and safe management of waste.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked emergency equipment and medicines regularly to ensure that it was in good working order when needed.

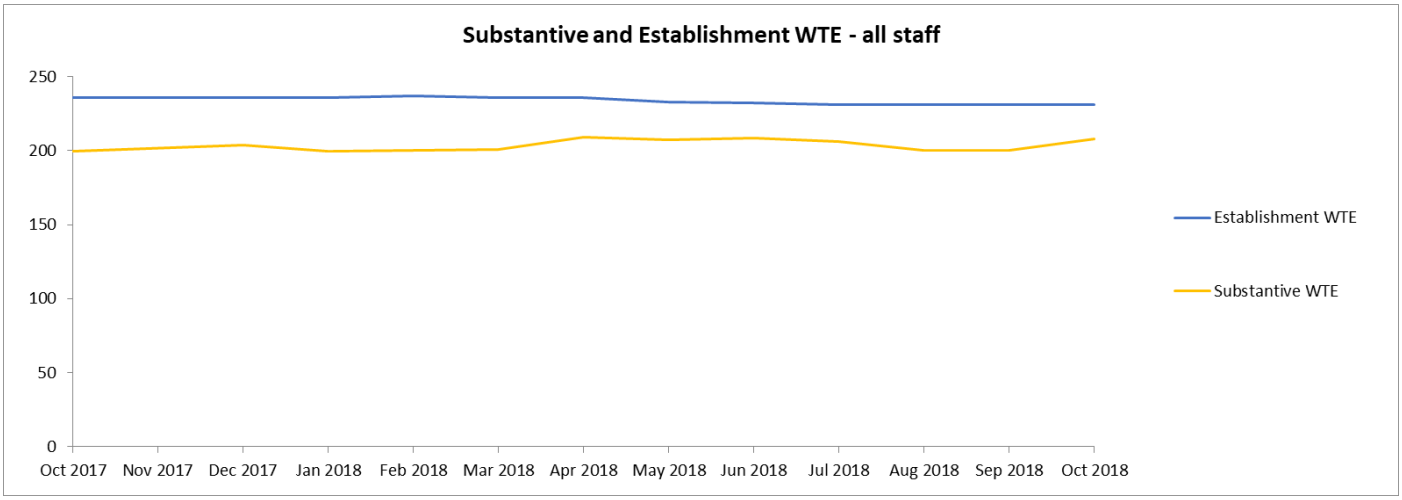
Staff maintained clinical equipment well and kept it clean. All clinical equipment had stickers to show completed safety checks. The stickers were clean and had visible dates to show when they were due for another test. However, all electrical equipment used by staff and patients in Brocton and Chebsey had gone past its due date for portable appliance testing. This was done the following day whilst we were on site.

Safe staffing

The wards had enough staff to meet the patients' needs, although they occasionally relied on bank and agency staff to fill shifts to cover sickness, absence or vacancies. Staff and patients told us that there were enough staff on shifts. Some staff told us that at times staff were taken from the wards to cover the 136 suites.

Managers had calculated the number and grade of nurses and healthcare assistants required. The managers told us they had used the safe care tool to calculate their staffing levels.

The below chart shows the breakdown of in post WTE by staff group in this core service between 1 October 2017 and 30 September 2018.



The below table covers staff fill rates for registered nurses and care staff during September 2018, October 2018 and November 2018.

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 (%)
	September 2018				October 2018				November 2018			
Laurel	109.2	173.3	98.9	323.5	107.4	160.4	100.9	319.1	104.4	155.2	100.5	280.4
Pine	87.7	129.5	99.0	233.8	94.2	161.1	101.3	303.2	105.7	129.4	99.1	240.3
Birch	110.4	165.9	102.2	247.1	106.3	165.3	97.0	241.9	133.8	151.4	101.6	216.7
Brocton	105.4	151.0	95.4	210.0	114.1	153.4	101.7	214.0	110.2	145.9	101.9	210.2
Chebsey	91.7	119.1	93.5	112.9	103.7	115.3	98.6	116.0	104.5	113.3	108.9	130.6
Norbury	88.4	198.4	89.7	189.1	103.8	193.4	97.5	198.1	101.9	212.8	98.3	203.3
GB West Wing	92.7	96.7	100.0	172.3	99.0	97.4	95.2	236.0	91.4	110.8	92.6	256.7

The rotas we looked at covered the number of nurses and healthcare assistants on most of the shifts. There were a number of shifts where staff were consistently above the required numbers of staff on duty. The extra staff were needed on duty to cover one to one observations or acuity of patients on the ward.

	Core service annual staffing metrics (1 October 2017 – 30 September 2018)						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of	Annual agency hours	Annual "unfilled" hours

					available hours)	(% of available hours)	(% of available hours)
All staff	234	13%	12%	6%			
Qualified nurses	112	15%	13%	4%	17575 (9%)	8286 (4%)	4751 (2%)
Nursing assistants	97	9%	13%	8%	73776 (41%)	26565 (15%)	18008 (10%)
Medical Staff	10	19%	0%	2%	0 (0%)	0 (0%)	0 (0%)
Allied Health Professionals	No data	No data	0%	5%			

The ward managers could adjust staffing levels daily to take account of case and skill mix. The managers reviewed the safer staffing system three times a day and staffing adjusted according to patients' needs. The safer staffing system was a live dashboard that calculated the level of staffing input required based on levels of bed occupancy, acuity of patients, activities, engagement and risks of patients to ensure that they met patients' nursing needs safely.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. The wards continuously reviewed the staffing levels and entered any changes into the safe care tool to determine the level of staffing required.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.

A qualified nurse was present in communal areas of the wards most of the times. We observed that the qualified nurses spent some time interacting with patients in the communal areas. However, some staff told us that nurses had a lot of paperwork to do which at times limited the time they could spend with patients.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients told us that they met regularly with their named nurses.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Patients and staff told us that leave, or activities were occasionally rescheduled but rarely cancelled.

There were enough staff to carry out physical interventions and observations safely, and staff had been trained to do so.

Figure 1

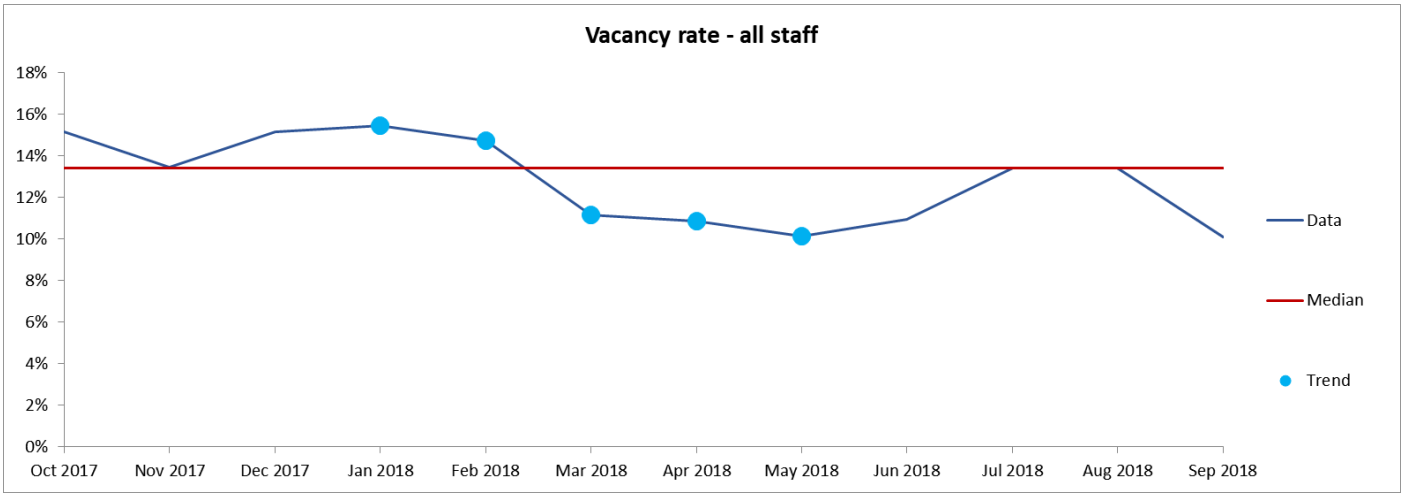


Figure 2

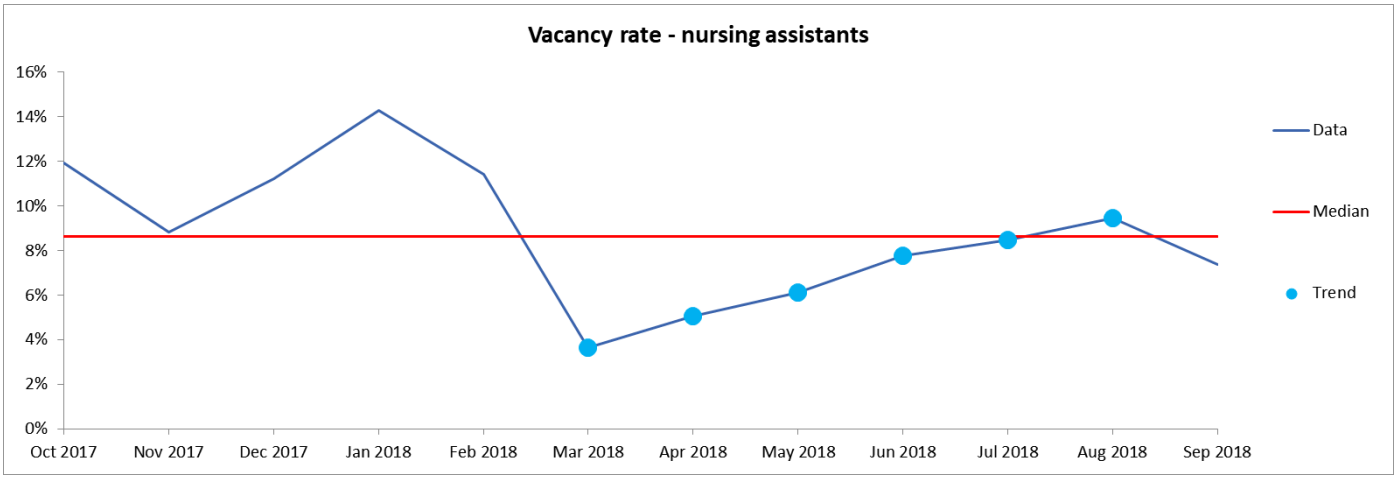
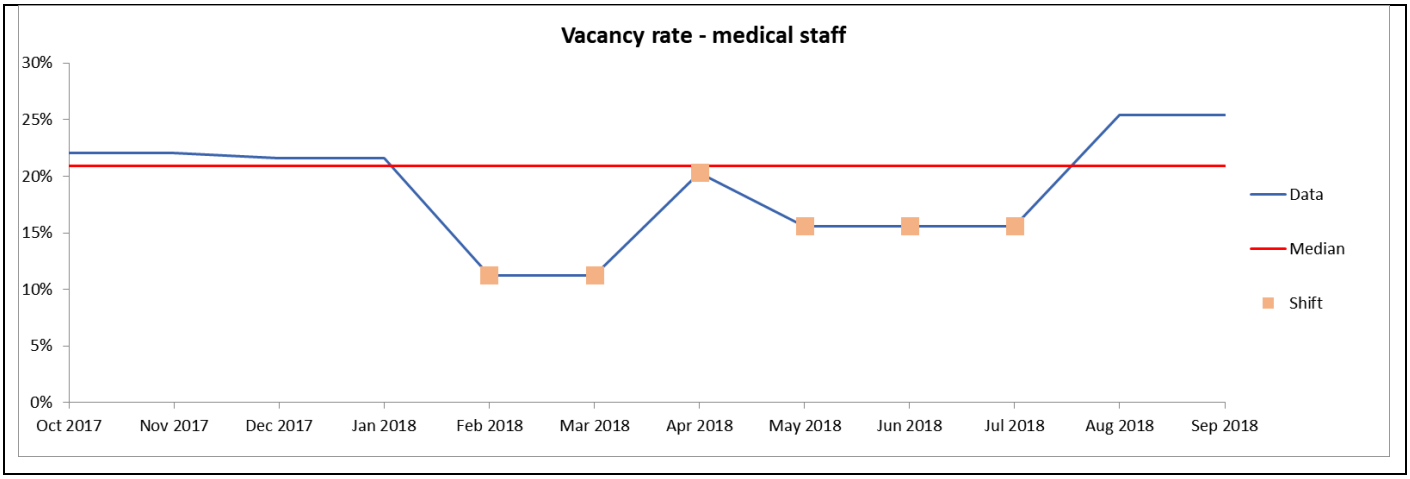


Figure 3



Key:

Median: the "middle" value in the list of numbers.
Shift: a shift is six points in a row either above or below the centerline.

All staff

The 'vacancy rate' data for ‘all staff’ showed a downward trend from January 2018 to May 2018, which could be an early indicator of improvement. The service had a strategy for recruitment and retention that was robust to reduce the vacancy rate.

Qualified nurses

The annual sickness rate for qualified nurses was 4%. This was in the lowest 25% of sickness rates reported to the CQC by similar core services.

Nursing assistants

The annual sickness rate for nursing assistants was 8%. This was in the highest 25% of sickness rates reported to the CQC by similar core services. The 'vacancy rate' data for nursing assistants shows an upward trend from March 2018 to August 2018, which could be an early indicator of deterioration. The service had a program in place to support nursing assistants to attend courses to train as nurse associates or nurse as part of career development.

A large proportion of nursing assistant staff hours (66%) were filled by bank and agency staff or remained unfilled. Most of the shifts covered by bank or agency were used to cover enhanced observations.

Looking at more recent safe fill rates within this core service data, Laurel, Pine, Birch, Brocton and Norbury ward all had above 125% of the planned care staff for all day and night shifts filled between September 2018 and November 2018. GB West Wing also had above 125% of the planned care staff for all night shifts filled over the same period.

Medical staff

Monthly vacancy rates for medical staff shows a shift from February 2018 to July 2018 (see figure 3). The trust recruited more medical staff and their links with the local university had given them the opportunity to have more medics on training. Bank and agency staff were not used to filled medical staff hours, over the 12-month period.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

Staff received appropriate mandatory training however, not all staff were up to date. Information governance and manual handling of people fell below 75%.

The compliance for mandatory and statutory training courses at 30 November 2018 was 84%. Of the training courses listed, 16 failed to achieve the trust target and of those, two failed to score above 75%.

The trust set a target of 90% for completion of mandatory and statutory training. The trust reports training on a month by month rolling basis.

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**
Conflict Resolution	12	12	100%	✓
Manual Handling - Object	11	11	100%	✓
Promoting Safer and Therapeutic Services	195	193	99%	✓
Corporate Induction	20	19	95%	✓
Local Induction	207	195	94%	✓
Mental Capacity Act Level 2	199	177	89%	✘
Safeguarding Adults (Level 1)	207	184	89%	✘
Safeguarding Children (Level 2)	207	183	88%	✘
Fire Safety Instruction & Evacuation - Level 3	173	153	88%	✘
Equality and Diversity	207	183	88%	✘
Adult Basic Life Support	194	168	87%	✘
Fire Safety - 1 Year	207	181	87%	✘
DMI - Foundation Violence & Aggression	185	158	85%	✘
Medicine management training	97	81	84%	✘
Prevent Awareness	207	170	82%	✘
Mental Health Act	102	82	80%	✘
Health and Safety (Slips, Trips and Falls)	20	16	80%	✘

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Clinical Risk Assessment	107	82	77%	✖
Infection Prevention (Level 1)	199	152	76%	✖
Information Governance	207	152	73%	✖
Manual Handling - People	195	113	58%	✖
Total	**3158**	**2665**	**84%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff carried out risk assessments on every patient at the initial assessment. However, one patient that was transferred from Laurel ward to Norbury ward did not have their risk assessment updated on admission to Norbury. We looked at 36 care records of patients and found that each of these contained a detailed risk assessment. The multidisciplinary team regularly reviewed and updated the risk assessments after every incident to reflect the changes in risk.

The wards used a recognised risk assessment tool. Staff assessed all patients and identified any risks associated with the patient. The risk assessment was followed by a management plan and where appropriate included a relapse prevention plan.

Management of patient risk

The service demonstrated good awareness and management of risks such as falls and pressure ulcers. Staff assessed all patients and identified any risks associated with these areas of risk.

Staff had clear monitoring systems in place that identified any changes in patients' risks and would respond effectively. This included different monitoring ways such as observations of mental state, food and fluid charts, sleep pattern and physical health observations. The teams reviewed the information and updated care plans to reflect any changes. The Safewards model was an approach used by all wards. The Safewards model encouraged the implementation of ten interventions to help minimise conflict on wards and maximise safety and recovery.

Staff followed the trust's policies and procedures for use of observations to minimise any risk of harm to patients or staff. Observations on patients were carried out in a therapeutic way and regularly reviewed to ensure that this was proportionate to the risk posed. Staff rarely conducted searches on patients and were only carried out where the risk was deemed high.

The service did not have a blanket restrictions approach to care and treatment. Staff individually risk assessed patients according to their level of ability and risk posed.

Staff adhered to best practice in implementing smoke-free policy. Patients were only allowed non-chargeable e-cigarettes to be smoked in designated areas within the hospital grounds.

Use of restrictive interventions

This service had 927 incidences of restraint (323 different service users) and 99 incidences of seclusion between 1 October 2017 and 30 September 2018.

The below table focuses on the last 12 months' worth of data: 1 October 2017 and 30 September 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Birch	14	67	4	11 (16%)	30 (45%)
Brocton	6	114	42	13 (11%)	34 (30%)

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Chebsey	1	98	49	13 (13%)	21 (21%)
Laurel	25	70	60	9 (13%)	27 (39%)
Milford*	0	3	3	0 (0%)	0 (0%)
Norbury	9	297	77	57 (19%)	34 (11%)
Pine	40	196	62	23 (12%)	80 (41%)
West Wing	4	82	29	13 (16%)	26 (32%)
Total	**99**	**927**	**323**	**139 (15%)**	**252 (27%)**

* Milford ward has been used for more than one purpose over the reporting period. Firstly, as a decant ward during the refurbishment of Norbury ward. it was then opened as a winter pressure ward supporting system flow. The ward was being used as an alternative to West Wing at the time of our inspection following a fire there.

There were 139 incidences of prone restraint, which accounted for 15% of the restraint incidents. Over the 12 months, incidences of restraint ranged from 50 per month to 100 per month. The number of incidences (139) had increased from the previous 12-month period (123).

Staff reported restraints appropriately. Staff told us that some of the restraints were planned to give depot injections and any minor intervention, including guiding patients away or minor holds were reported as restraint. All incidents of restraint were reported through the incident reporting system and reviewed by the multidisciplinary team.

Staff focused on methods of de-escalation and only used restraint as a last resort. Management plans had different proactive methods that could be used by staff before any restrictive methods such as restraint or rapid tranquilisation could be used. The trust trained staff in physical intervention and they were aware of the techniques required.

Staff understood and where appropriate worked within the Mental Capacity Act of restraint.

The trust had taken positive steps towards implementing a reduction in restrictive practice. There was a review of least restrictive practice in all wards every week in staff huddles. A huddle was an informal meeting of staff to review risk, demand and progress on innovations within the service. They had been introduced to supplement more formal handovers and had a common agenda set out on an activity (huddle) board in each clinical area.

There were 252 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from eight per month to 34 per month between October 2017 and September 2018. The number of incidences (252) had decreased from the previous 12-month period (269).

In our last comprehensive inspection in March 2016 we told the trust that they must ensure their policy on rapid tranquilisation was up-to-date and reflected current prescribing guidance that staff must follow. On this inspection we found that improvements had been made. The trust had an up to date policy on rapid tranquilisation that followed the National Institute for Health and Care Excellence (NICE). Although staff followed the policy in most of the incidents there were two cases in Birch ward where no follow up intervention was taken after the physical observations. This was where the National Early Warning Score from the observations was high enough to trigger a medical review.

There have been two instances of mechanical restraint over the reporting period. The number of incidences (2) had increased from the previous 12-month period (1).

There were 99 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from two per month to 13 per month. The number of incidences (99) had increased from the previous 12-month period (77).

In our last comprehensive inspection in March 2016 we told the trust that they must ensure compliance with the Mental Health Act Code of Practice requirements for recording observations and reviews regarding use of seclusion and long-term segregation. We found that the trust had reviewed this policy and improvements had been made. The trust had also developed a policy on how patients were to be transferred from a ward without a seclusion room to one with a purpose-

built seclusion room when needed in exceptional circumstances. Norbury transferred three patients to use a seclusion room in Newport on three occasions in the last 12 months.

Although all the wards within this core service did not have designated seclusion rooms, staff followed the meaning of seclusion within the Mental Health Act Code of Practice when they restricted the movement of a patient to a specific area. This meant patients were at times secluded in areas that were not designated as purpose built seclusion rooms when needed to manage risk. Staff used seclusion appropriately and followed best practice when they did so. This was in line with the policy and the Mental Health Act Code of Practice.

The wards kept seclusion records in an appropriate manner and were reviewed by the multidisciplinary team.

There had been six instances of long-term segregation over the 12-month reporting period. The number of incidences (6) had increased from the previous 12-month period (1).

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 at risk 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 at risk, 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 56 safeguarding referrals between 1 October 2017 and 30 September 2018, of which 51 concerned adults and five children.

The trust had submitted details of two serious case reviews commenced or published in the last 12 months (1 October 2017 to 30 September 2018). None related to this core 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 followed the trust's policy for children visiting the wards to ensure safety. Staff discussed, and risk assessed visits from children considering any child protection issues. There were meeting rooms away from the wards where visiting children could meet with patients safely.

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.

Staff used paper records for observations and prescription charts and this did not cause any difficulties in entering or accessing information.

Medicines management

Staff followed good practice when storing, transporting, dispensing, administering, disposing and recording the use of medicines. This was done in line with national guidance.

The teams reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence guidance. The wards ran weekly physical health clinics.

Track record on safety

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

Between 1 October 2017 and 30 September 2018 there were five serious incidents reported by this service.

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 five 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.

	Number of incidents reported			
Type of incident reported (SIRI)	**Slips / Trips / Falls**	**HCAI/Infection control incident**	**Abuse/alleged abuse of adult patient by third party**	**Total**
Milford*	2	1	0	**3**
Norbury	0	1	1	**2**
Total	**2**	**2**	**1**	**5**

* Milford ward has been used for more than one purpose over the reporting period. Firstly, as a decant ward during the refurbishment of Norbury ward. it was then opened as a winter pressure ward supporting system flow. It is not currently an active ward.

Reporting incidents and learning from when things go wrong

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 gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents and shared lessons learnt with their teams and the wider service. Staff received feedback from the investigation of incidents both internal and external to the service. Staff had daily safety meetings to discuss that feedback any safety issues on the wards.

The service made changes to practice as a result of learning from incidents. The teams made changes to handovers and updated their absence without leave form following lessons learnt from incidents.

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

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient on admission. We looked at 36 patients' care records that showed that staff assessed the mental health needs of all patients in a timely way and identified all patients' needs.

The medical staff assessed patients' physical health needs in a timely manner soon after admission. Staff ensured that all patients had a physical examination within 24 hours of admission and recorded any physical health problems.

Care plans reflected the assessed needs. Staff developed care plans that met the needs identified during assessment. The care plans contained clear details of what they aim to achieve and on how each identified need was to be addressed.

Staff had written personalised, holistic and recovery orientated care plans in 31 out of the 36 examples we reviewed. Staff together with patients regularly reviewed and updated them when needed and 29 out of 36 care plans included the patients' views and own goals.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. We looked at the interventions set out in 36 patients' care records and medicine prescriptions and found they were delivered in line with National Institute for Health and Care Excellence guidance. These included medication and psychological therapies and, when needed, support for housing and benefits, and interventions that enable patients to acquire independent living and social skills.

The service offered a wide range of activities to patients. The occupational therapists assessed patients and encouraged them to actively engage in routine meaningful and purposeful structured daily programme of activities. On Norbury ward there was additional support for those with sensory challenges. Patients received sensory assessments and had access to a sensory room that addressed their individual needs.

There was good prescribing; most of the patients were on one antipsychotic drug within British National Formulary (BNF) levels. Patients' medication was reviewed regularly, that included information on possible drug interactions, minimum effective doses, contra-indications, side effects and health checks required. Staff monitored and reviewed the effectiveness of the medicines prescribed. Patients were monitored for weight, blood pressure, fasting blood glucose and lipids.

Staff ensured that patients had good access to physical healthcare. Staff ensured that patients' physical healthcare needs were being met through their well-structured weekly physical health clinic. They had dedicated and trained staff to run the physical health clinics. When needed, patients had good access to physical healthcare specialists. Patients told us that they had access to different professionals and specialists for their physical health problems.

Staff assessed patients' needs for nutritional and hydration needs and referred them to the dietician if required. Staff monitored fluid and food intake for patients that had nutritional and hydration needs, and records were reviewed daily

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

The teams 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, the computerised sensory room in Norbury, online access to therapies and sharing patient information across the service.

Staff participated in clinical audit, benchmarking and quality improvement initiatives to monitor and improve the effectiveness of the service provided. The teams discussed clinical safety of the service through weekly staff huddles where areas of improvement, action plans and dashboard results were discussed. Staff could give examples of where practice had been identified as requiring improvement and how changes were addressed to improve the service.

This service participated in three clinical audits as part of their clinical audit programme 2018 - 2019.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Preventing Ill Health CQUIN Audit – Q1	Adult Mental Health Services (Inpatients)	Clinical Audit	June 2018	All teams involved in the CQUIN produce individual plans to meet the CQUIN requirements, Actions are also being managed as part of a wider CQUIN action plan.
Preventing Ill Health CQUIN 9 – Q2	All Mental Health inpatient admissions during Quarter 2.	Clinical Audit	October 2018	Teams have developed local action plans to address individual results, which are also incorporated into a wider CQUIN action plan, managed by the professional lead.
Preventing Ill Health by Risky Behaviours – alcohol and tobacco CQUIN	Mental Health inpatient admissions during January, February and March 2018	Clinical Audit	April 2018	Individual team action plans are being agreed against the objectives detailed in the inpatient/community action plans (supported by project lead). Specific support will be provided to teams where required to support improvements. Local inductions in inpatients to cover trainee doctors understanding of their role in completing the assessment of alcohol and tobacco and know how to record them on RiO.

Skilled staff to deliver care

The teams included a full range of specialists required to meet the needs of patients under their care. This included doctors, nurses, advanced practitioners, occupational therapists, clinical psychologists, pharmacist, social workers, associate nurses, support workers and peer 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 an appropriate induction. The service had an induction programme for all new staff including agency staff. However, the ward induction programme needs to be comprehensively structured to cover issues such as anti-barricade to agency and new staff. Healthcare assistants had access to training equivalent to the care standards certificate.

Managers ensured that staff received the necessary specialist training for their roles. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff had access to a wide range of training in addition to their mandatory training.

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

Peer support workers were recruited when required and managers trained and supported them for their roles.

Managers ensured that staff had access to regular team meetings. The teams had weekly staff huddles and held four to eight weekly staff meetings. Staff attended group supervision sessions where they discussed patient clinical information, reflection and lessons learnt.

The trust was not able to provide data on clinical supervision compliance for both non-medical and medical staff.

In our last comprehensive inspection in March 2016 we told the trust that they should ensure that staff receive regular supervision in line with local policy and professional guidelines. The trust policy in place at the time of our inspection of these services states that 'For staff delivering clinical services, they will attend a minimum of six managerial supervision sessions and twelve clinical supervision sessions annually.' Allowing for the two types of supervision to be combined on occasion that that means each staff member should receive on average one session of supervision per month. In our 2016 report we set out that 'the average (for Jan, Feb and March 2016) percentage of nursing staff having received monthly supervision on the wards (allowing for absences for sickness and leave) were; Redwoods (50.5%) Laurel ward 53%, Pine ward 48% and at St Goerge's and George Bryan Centre (62%) Brocton ward 70%, Chebsey ward 68 %, Norbury PICU 71% and West Wing 42%. Across all the wards the average was 59%.

On this inspection the following data was submitted for the two sites:

Apr 2018 - Mar 19 Redwoods (66% overall) Laurel 75%, Pine 68%, Birch 53% At the St Georges site for Jan -Dec 2018 (62% overall); Norbury 51% Chebsey 66% Brocton 76% and West Wing/Milford 54%

Across all the ward the average was 63% over a year but the periods reported were overlapping. This did not represent a significant improvement since our last inspection.

Wards at the Redwoods centre demonstrated that staff received regular one to one supervision. Managers for Brocton, Chebsey, Norbury and Milford wards did not provide staff with regular one to one management supervision that was recorded in line with the trust policy for personal support, professional development and work performance.

We looked at staff supervision records at St George's and found out that most of the staff had not documented one to one supervision for over 6-12 months. The supervision tracker was regularly updated but there were no documented records of one to one supervision to match the information on the tracker. The managers told us that they needed to improve on their recording of supervision. Staff in Norbury could not provide us with the supervision records and told us it was difficult to have one to one supervision due to pressure of work in the ward. The service failed to provide staff with six managerial supervision sessions in 12 months as required by the trust policy.

Given the challenging nature of working on an acute psychiatric ward we believe the lack of regular supervision and failure to record sessions left staff without the benefits regular supervision offers and no way to evidence and review development plans between annual appraisals.

The trust's target rate for appraisal compliance is 90%. 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 87%. This year so far, the overall appraisal rate was 96% (as at 30 November 2018).

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 30 November 2018)**	**% appraisals (1 April 2017 – 31 March 2018)**
GB West Wing Tamworth	15	15	100%	88%

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 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
Pine Redwoods	16	16	100%	93%
Laurel Redwoods	22	22	100%	89%
Brocton Stafford	25	25	100%	61%
Chebsey Stafford	24	23	96%	88%
Norbury Stafford	37	34	92%	92%
Birch Redwoods	22	19	86%	100%
Core service total	**161**	**154**	**96%**	**87%**
Trust wide	**4490**	**3615**	**81%**	**88%**

The trust's target rate for appraisal compliance is 90%. 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 was 75% (as at 30 November 2018).

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
Laurel Redwoods	1	1	100%	N/A
GB West Wing Tamworth	2	2	100%	100%
Brocton Stafford	2	2	100%	100%
Chebsey Stafford	1	1	100%	100%
Birch Redwoods	1	0	0%	100%
Pine Redwoods	1	0	0%	100%
Core service total	**8**	**6**	**75%**	**100%**
Trust wide	**137**	**77**	**56%**	**80%**

The managers provided staff with appraisals for their work performance. However, most told us they did not have sessions in between the year to follow up on discussion from the start of appraisal performance.

Multidisciplinary and interagency team work

The wards had regular and effective multidisciplinary team meetings. Professionals from different disciplines worked together as a team to benefit patients. They held in-depth discussions that addressed the identified needs of the patients such as risk, safeguarding issues, physical health issues, medication review, discharge planning and changes to care plans.

Staff shared information about patients effectively to ensure that patients had no gaps in their care. The wards held handovers at the end and start of each shift, daily safety meetings on each shift and weekly team meetings.

The teams had effective working relationships with other relevant teams within the organisation. They worked well, including good handovers and regular discussions with the community mental health teams and home treatment teams. They also invited them to multidisciplinary team meetings to discuss any future discharge plans.

The service had good working relationships and strong links with relevant external organisations. They worked closely with the primary care, acute hospitals, police, local community facilities, the local authority, charity organisations, housing associations and commissioners.

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

As of 30 November 2018, 80% 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 for inpatient and all community staff and renewed every three years.

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

The trust 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.

Patients had easy access to information about independent mental health advocacy. Staff were aware of how to access and support patients to engage with the independent mental health advocate when needed.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Patients we spoke with confirmed that their rights under the Mental Health Act had been explained to them.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Staff made patients and their carers aware of the conditions of leave and any risks and advised them on what to do in the event of emergency.

Staff requested an opinion from a second opinion appointed doctor when necessary. Consent to treatment and capacity forms were appropriately completed and attached to the medication charts of detained patients.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly, so that they were available to all staff that needed access to them.

All wards displayed a notice to tell informal patients that they could leave the ward freely.

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.

The Mental Health Act Administrators carried out regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

As of 30 November 2018, 89% of the workforce in this service had received training in the Mental Capacity Act Level 2 The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

Staff had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles.

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 regarding significant decisions.

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 had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

The trust told us that seven Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 October 2017 and 30 September 2018.

The greatest number of DoLS applications were made in May 2018 with two.

CQC received a total of 129 direct notifications from the trust between 1 October 2017 and 30 September 2018. This is more than double the number the trust told us about in the PIR. We are unable to break these down by core service.

	Number of 'Standard' DoLS applications made by month (Trust data)												
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	**Total**
Standard applications made	0	0	1	1	0	0	1	2	0	0	1	1	**7**
Standard applications approved	0	0	1	0	0	0	0	0	0	0	0	0	**1**

	Number of 'Urgent' DoLS applications made by month (Trust data)												
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	**Total**
Urgent applications made	0	0	1	1	0	0	0	2	0	0	1	1	**6**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness, dignity and respect. We observed that staff were, polite and respectful when interacting with patients. They were responsive to patients' requests and provided them with timely help, emotional support and advice when needed.

Staff supported patients to understand and manage their care, treatment or condition. They gave patients information required to understand the importance of their treatment or directed them to suitable services. Staff encouraged patients to know how best to take control of their treatment and condition.

The teams gave patients the right support that 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 highly and positively about the way staff treated them.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff considered the differences in their individual patients in their approach to treatment and care by taking patients' opinions and beliefs acting upon them.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. The wards promoted a culture of openness and patient safety.

Staff maintained confidentiality of information about patients on the wards. Confidential information was always kept secure electronically or locked away and handovers and meetings were conducted privately.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at all three service locations scored higher than similar organisations. All patients we spoke with spoke positively about their privacy, dignity and wellbeing at the service.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	98.9%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units Wards for older people with mental health problems	92.1%
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	96.2%
Trust overall		**96.9%**
England average (mental health and learning disabilities)		**91.0%**

Involvement in care

Involvement of patients

Staff used the admission process to orient patients to the wards. All patients told us they were shown around the ward, were offered drinks and given an information pack about the ward. Staff explained the ward routine to patients, including meal times and items that were not allowed. Staff also introduced patients to other patients and staff.

The teams involved patients in care planning and risk assessment and participation in multidisciplinary team reviews. Staff offered patients as much choice as possible about their care and treatment. Patients had access to a copy of their care plan.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff took their time to explain things to in an easily understandable way at the level at which a patient could understand.

The service 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 meetings and support from peer support workers. Patients in Milford ward had been consulted on the way the ward was set following the transfer of the service from the George Bryan Centre.

The teams enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate. Brocton and Chebsey wards had very good examples of how they raised awareness and respected patients' advance decisions.

Staff ensured that patients could access advocacy. Information on advocacy was readily available to patients. The advocates visited the wards regularly.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff gave families and carers an information pack about the service when a patient was admitted to the ward.

The service 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 with information about how to access a carer's assessment.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for all seven wards in this service between 1 October 2017 to 30 September 2018.

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

The managers told us the pressure for beds varied from time to time, at times the beds were readily available and at times not available at all.

The managers reported that there was a high demand for beds, but it was very rare that a bed for someone on leave was occupied if they certainly knew the patient was returning.

Ward name	Average monthly bed occupancy range (1 October 2017 – 30 September 2018)
Laurel Redwoods	89.31% - 103.63%
Brocton Stafford	88.81% – 97.14%
Pine Redwoods	88.10% - 103.54%
GB West Wing	87.50% - 103.71%
Birch	86.49% - 107.50%
Chebsey Stafford	84.91% - 97.28%
Norbury Stafford	0.00% – 94.48%

The trust provided information for average length of stay for the period 1 October 2017 to 30 September 2018.

Ward name	Average monthly length of stay range (1 October 2017 – 30 September 2018)
Norbury Stafford	0.0 – 238.00
Birch	17.81 – 120.00
Laurel Redwoods	14.82 – 73.85
GB West Wing	16.33 – 57.40
Pine Redwoods	15.16 – 44.33
Brocton Stafford	10.16 – 39.27
Chebsey Stafford	7.16 – 36.93

Chebsey ward had the lowest average length of stay and this ward had 11 patients and eight vacant beds on the day of inspection and one was later discharged that afternoon.

This service reported 41 out area placements between 1 January 2018 and 30 September 2018. As of 10 December 2018, this service had three ongoing out of area placements. None of the placements lasted less than one day and the placement that lasted the longest amounted to 105 days.

Thirty-six out of 41 out of area placements were due to capacity issues while the remaining five were due to another provider as it would better suit their care or personal needs.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
41	5	36	2 – 105	3

A bed was always available for male patients in a psychiatric intensive care unit (PICU) if a patient ever required more intensive care. Male patients from Shropshire had to move to St George's hospital. Female patients had to go out of area for intensive care.

The service very rarely moved patients between wards during an admission episode and only ever did so based on clinical grounds.

The service discharged patients at an appropriate time of the day. The multidisciplinary team planned and coordinated the discharges well in advance.

This service reported 220 readmissions within 28 days between 1 October 2017 and 30 September 2018. One hundred and five of the readmissions (48%) were readmissions to the same ward as discharge. The average number of days between discharge and readmission was 10 days. There were 15 instances whereby patients were readmitted on the same day as being discharged and there were 20 where patients were readmitted the day after 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
Norbury	1	1	100%	4	4
Birch	22	8	36%	0 – 26	7
Pine	44	30	68%	0 – 28	8
GB West Wing	18	7	39%	0 – 28	10
Brocton	47	19	40%	0 – 28	10
Chebsey	66	33	50%	0 – 28	10
Laurel	22	7	32%	0 – 28	12
Total	**220**	**105**	**48%**	**0 – 28**	**10**

Discharge and transfers of care

Between 1 October 2017 and 30 September 2018 there were 1385 discharges within this service. This amounts to 38% of the total discharges from the trust overall (3682). Three percent of the discharges from this core service were delayed.

Ward name	Number of discharges	Number of delayed discharges	% Delayed
Milford*	10	2	20%
Chebsey	373	17	5%
Birch	172	5	3%
Brocton	205	6	3%
Pine	220	2	1%
GB West Wing	208	2	1%
Laurel	162	2	1%

Ward name	Number of discharges	Number of delayed discharges	% Delayed
Norbury	35	0	0%
Total	**1385**	**36**	**3%**

The number of delayed discharges were very low across the service and these were sometimes for non-clinical reasons. This was mainly due to a lack of specialist placements for the patients that had complex needs that were difficult to place.

Staff planned for patients' discharge, including good liaison with care coordinators. The service had social workers in the teams to work on accelerating and facilitating discharges to avoid any delayed discharges.

Staff supported patients during referrals and transfers between services. Staff would always support patients if they were transferred to an acute hospital for treatment or clinical reasons.

Facilities that promote comfort, dignity and privacy

All the wards at the Redwoods Centre and Milford ward had bedrooms with ensuite bathroom facilities. Chebsey and Brocton wards had a mixture of bedrooms with ensuite and without. Norbury had no ensuite facilities. The environments were spacious and had plenty of room for patients to relax apart from Milford which had limited rooms for patients to relax away from the main communal areas.

Patients could personalise their bedrooms on the wards. Patients could display photos, posters and had televisions in their rooms.

Patients had somewhere secure to store their possessions. Patients had locked cabinets and could lock away their valuable possessions. Some patients had keys to their bedrooms.

Staff had access to a full range of rooms and equipment to support treatment and care. The wards had clinic rooms, large activity rooms and access to therapy rooms and occupational therapy kitchens. Milford had limited rooms for therapies and quiet areas. All patients had access to a laundry room where they were encouraged to take responsibility for their laundry. Patients had access to quiet areas on the ward.

Norbury had a state of the art sensory room and a well-equipped gym.

Most patients had their own personal mobile phones on the wards and could always make phone calls in private. Staff told us patients without personal mobile phones could use the phones in private in some of the meeting or quiet rooms.

Patients had access to outside space in all wards. Patients could access the outside space throughout the day.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the three locations scored higher than similar trusts.

All patients told us that the food was of good quality and they enjoyed it. Only two patients told us they could do with a wider variety of menu choice.

Site name	Core service(s) provided	Ward food
St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Other specialist services Secure wards / Forensic inpatient Wards for older people with mental health problems	95.6%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units Wards for older people with mental health problems	96.0%
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units	93.5%

Site name	Core service(s) provided	Ward food
	Secure wards / Forensic inpatient Wards for older people with mental health problems	
Trust overall		**94.9%**
England average (mental health and learning disabilities)		**92.2%**

On all acute wards apart from Milford, patients had free access to the kitchen to make hot drinks and have a snack throughout the day and night. On Milford ward, patients had access to the kitchen with staff support until the necessary changes were made to the kitchen area to reduce risk. On Norbury ward some patients were deemed to be at risk to have access to hot drinks on their own but staff would make them drinks.

Patients' engagement with the wider community

The wards worked with charity organisations to encourage that patients had access to education and work opportunities. At St George's the charity organisation was based on the hospital site.

Staff supported patients to maintain contact with their families and carers. The service invited carers and families to take part in treatment reviews if they wished to do so. Patients were supported to have leave for home visits and community access.

Staff encouraged patients to develop and maintain relationships with people that mattered to them whilst within the service. The wards had specific visiting times for families and carers so that they could visit their relatives.

Meeting the needs of all people who use the service

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the three locations scored higher than similar trusts for the environment being dementia friendly and for the environment supporting those with disabilities.

Site name	Core service(s) provided	Dementia friendly	Disability
St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Other specialist services Secure wards / Forensic inpatient Wards for older people with mental health problems	98.1%	98.1%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units Wards for older people with mental health problems	95.3%	95.4%
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	99.0%	99.0%
Trust overall		**98.1%**	**98.1%**
England average (Mental health and learning disabilities)		**88.3%**	**87.7%**

The service made all the necessary adjustments for disabled patients to access the wards. The wards had specialist beds available if they needed them. All wards also had assisted bathroom facilities with all the equipment to support disabled people. To support patients with learning

disabilities there was a learning disabilities liaison nurse employed to support staff to meet their needs.

Information relevant to patients' treatment and care was available on all wards. Staff ensured that patients could obtain information on treatment, medicines, local services, patients' rights and how to complain. Staff provided patients with information in the welcome pack when they arrived on the wards.

The information provided was in an accessible format for the patient group. The information was written in a simple easy to understand format. Where they needed further, simplified information it was done on an individual basis with the help from speech and language therapists from the learning disabilities team. However, there was no readily available information that was relevant about day to day running of the services in an easy read format for people with learning disabilities.

The service made information leaflets in multiple languages if they were required. Staff knew how to obtain information in different languages if needed.

Managers ensured patients had access to interpreters or signers if they needed them. Staff knew how to get in touch with interpreting services.

Patients had a choice of food and they could pick what they wanted each day. The service also offered food that could meet the religious and ethnic needs of patients, as well as having vegetarian and diabetic options.

Staff ensured that patients had access to appropriate spiritual support on the wards. The trust provided a multi-faith chaplaincy service that patients had access to if they wanted to. Multi-faith information and material was available on the wards.

Listening to and learning from concerns and complaints

This service received 10 complaints between 1 October 2017 and 30 September 2018. One was fully upheld, two partially upheld and six not upheld. One is still under investigation.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
George Bryan Centre West Wing	**3**	0	1	1	0	1	0	0
Brocton	**3**	0	1	2	0	0	0	0
Pine	**2**	1	0	1	0	0	0	0
Birch	**1**	0	0	1	0	0	0	0
Laurel	**1**	0	0	1	0	0	0	0
Total	**10**	**1**	**2**	**6**	**0**	**1**	**0**	**0**

This service received 67 compliments during the last 12 months from 1 October 2017 to 30 September 2018 which accounted for 0.6% of all compliments received by the trust.

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 managers investigated complaints and learnt 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

The ward managers and the matrons had the skills, knowledge and experience to perform their roles. They had all worked in the service for a long time and had progressed through the positions within the service,

They demonstrated good understanding of the needs of their teams and patient group. They clearly explained how the teams worked and what were the future plans to achieve high quality care and the goals of the service.

The 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.

The managers and junior staff at all levels were given opportunities in leadership and development training. All staff within the teams had access to leadership training as part of their ongoing professional development plan.

Vision and strategy

Staff knew and understood the trust's vision and values and how they were applied in their everyday work within the team. Staff could tell us in detail about their values.

The trust's senior leadership team had effectively communicated the provider's vision and values to the frontline staff in this service. The leaders knew very well 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 asked for ideas and 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 by their line managers. However, there was mixed feelings about senior management support from staff on Milford ward. Some staff felt they did not get adequate psychological support from the senior management after the fire incident at the George Bryan Centre West Wing. Most of the 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.

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

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

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression through offering equal opportunities for all. Staff told us that the trust was always raising awareness of equality and diversity and there was an equality and diversity lead within the trust. Staff were encouraged to attend forums on equality and diversity.

The service's staff sickness and absence rate of 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. There were other ward level staff awards such as a care plan award in Brocton and Chebsey wards.

Governance

The service had effective operational governance processes to manage quality and safety. The teams demonstrated that governance processes operated effectively at ward level. All wards had methods of reporting key information to senior management.

All key information such as incidents, complaints, safeguarding, staffing, training and bed management reported by staff to senior management was analysed. The results of these key areas formed part of the framework of what was discussed at ward or service level and any learning was shared and discussed. However, managers did not routinely collect data on the clinical supervision of staff or review supervision records to identify themes and common concerns. The lack of regular staff supervision limited the impact of learning lessons from incidents. Managers had not prioritised the effective supervision of staff that would support their clinical practice and individual wellbeing.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the trust and external, to meet the needs of the patients. There were good working relationships with the community mental health teams, acute hospitals, local authority and GPs.

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. However, we found that Milford ward had not implemented a ward level risk register. Staff had concerns that needed to be on the risk register. This was completed the following day whilst on site.

The service had plans for emergencies that explained measures the service would take to ensure the safety of patients in the event of an emergency or adverse weather conditions.

There were no cost improvements in place at the time of inspection. The service had introduced a programme to work towards environmentally friendly guidelines to go paperless, and recycling to reduce harm to the environment.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Staff reported that methods used to give information to senior management were easy to use.

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. Staff had laptops on the wards which allowed them flexibility to access and write patients notes from anywhere within the wards. The trust's intranet provided staff with easy access to all relevant information such as trust news, policies and sharing good practice.

Information governance systems included confidentiality of patient records. There were systems to protect patients' data both electronic and paper based.

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. They had access to a dashboard which covered a wide range of key areas of service performance and any identified areas of improvement. Managers kept staff updated with this information which was readily available on weekly team huddles.

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

Staff made all notifications to external bodies as needed. Care Quality Commission received relevant notifications as required. Local authority received safeguarding and application of Deprivation of Liberty Safeguards notifications.

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 had a website with information about the services. The trust used many ways to keep their staff, patients and carers well informed and up to date about the service. They used intranet, emails, newsletters, noticeboards and face to face meetings.

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

The service welcomed feedback from patients, carers and staff and the managers used it to make improvements. There were 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. Leaders used a listening into action programme to get feedback from staff. The managers took the feedback from surveys and listening into action seriously.

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. There were lead nurses allocated for key areas of clinical practice such as infection control, physical health, care planning, healthy life style, carers and so on. These members of staff took lead in implementing best practice and improvements in these key clinical areas.

Staff had opportunities to participate in research. For example, the occupational therapist from Norbury took part in sensory integration research that focussed on patient clinical benefits.

Innovations were taking place in the service. For example, they had implemented the patient event associated learning protocol (PEARL), where staff were encouraged to present learning from patient events.

Staff used quality improvement methods and knew how to apply them. They were trained in different methods of quality improvement. The service had implemented a programme to improve quality in restrictive practice focussing on physical restraint, rapid tranquilisation, seclusion and Mental Capacity Act.

Staff participated in national audits relevant to the service and learned from them.

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 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
AIMS WA (Working Age Units)	Brocton Ward – 17 Jan 2017 Chebsey Ward 6 March 2018
AIMS – PICU (Psychiatric Intensive Care Units)	Norbury Ward – March 2017

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)
George Bryan Centre	ISFOP GB East Wing Tamworth	12	Mixed
St George's Hospital	ISFOP Baswich Stafford	12	Mixed
St George's Hospital	ISFOP Bromley Stafford	14	Mixed
The Redwoods Centre	IDEM Oak Redwoods	16	Mixed
The Redwoods Centre	IFNCT Holly Redwoods	16	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 this service safe?

Safe and clean environment

Safety of the ward layout

Staff carried out regular risk assessments of the ward environments. Ward layouts combined with zonal staffing arrangements allowed staff to observe all parts of ward. Zonal staffing was a system that managers used to ensure all areas of the wards had staff presence. It meant breaking the ward into parts (zones) that could be directly observed. Managers identified staff members to work in each area of the wards. This reduced the risk of staff having to cover the whole ward in a short space of time to complete a round of observations.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff answered alarms and nurse call bells in a timely manner.

Over the 12-month period from 1 October 2017 to 30 September 2018 there were no same sex accommodation breaches within this service.

The ward complied with guidance on eliminating mixed-sex accommodation. All patients had a single room, most of which contained ensuite bathing and toilet facilities. Those without ensuite facilities had access to gender specific toilets very close by. Each ward had a female only lounge and a mixed gender lounge for therapeutic activities. Some activities, such as using the gym, were also gender specific.

There were ligature risks on five wards within this service. All wards had carried out a ligature risk assessment within the last 12 months.

These risk assessments identified the ligature anchor points. A ligature anchor is a fixed point to which one might tie something, in order to harm oneself. Staff were aware of the ligature risks on their wards and mitigated for these risks using individual patient risk assessments, patient observations and specific care plans to manage the risks. At the time of inspection, the trust was carrying out an investigation into the circumstances surrounding the death of a patient who had tied a ligature whilst being treated on Bromley Ward.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. Maintenance teams responded quickly when staff reported issues.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. Staff who carried out the cleaning had access to the supplies they needed and worked with clinical staff to ensure the wards remained visibly clean and well ordered.

Staff adhered to infection control principles, including handwashing. Staff, visitors and patients were encouraged to adopt good hand hygiene routines.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the locations scored higher than similar trusts for cleanliness and for condition, appearance and maintenance.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	99.6%	99.3%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units	100.0%	99.4%

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
	Wards for older people with mental health problems		
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	99.5%	99.3%
Trust overall		**99.6%**	**99.3%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff maintained equipment well and kept it clean. Any ‘clean’ stickers were visible and in date.

Safe staffing

Nursing staff

This core service had reported a vacancy rate for all staff of 5% as of 30 September 2018. This broke down to a vacancy rate of 5% for registered nurses and 6% for healthcare assistants.

		Registered nurses			Healthcare assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
George Bryan Centre	GB East Wing Tamworth	2.1	13.0	16%	1.5	12.5	12%	3.4	29.1	12%
Redwoods Centre	Oak Redwoods	-0.6	13.4	-4%	2.3	17.0	14%	1.7	34.8	5%
St Georges Hospital	Bromley Stafford	1.6	13.4	12%	1.1	12.4	9%	1.2	29.3	4%
Redwoods Centre	Holly Redwoods	1.3	13.8	9%	-0.8	12.1	-7%	1.4	33.3	4%
St Georges Hospital	Baswich Stafford	-1.2	14.6	-8%	0.3	23.2	1%	0.0	40.7	0%
Core service total		**3.1**	**68.2**	**5%**	**4.4**	**77.2**	**6%**	**7.7**	**167.2**	**5%**
Trust total		**140.5**	**1969.7**	**7%**	**146.8**	**1424.0**	**10%**	**536.1**	**5645.8**	**9%**

Between 1 October 2017 and 30 September 2018, of the (133,975) total working hours available, 5% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reasons for bank and agency usage for the wards/teams were vacancies and long sickness. In the same period, agency staff covered 3% of available hours for qualified nurses and 3% of 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	%
Oak Redwoods	26423	2413	9%	1043	4%	722	3%
Holly Redwoods	27294	1210	4%	738	3%	1030	4%
Baswich Stafford	28580	1066	4%	1104	4%	1052	4%
Bromley Stafford	26231	1113	4%	701	3%	455	2%
GB East Wing Tamworth	25448	1089	4%	368	1%	1279	5%
Core service total	133975	6891	5%	3953	3%	4538	3%
Trust Total	**3781640**	**96462**	**3%**	**38953**	**1%**	**25030**	**1%**

Between 1 October 2017 and 30 September 2018, of the (138,062) total working hours available, 19% 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/teams were vacancies and long sickness. In the same period, agency staff covered 5% of available hours and 6% of 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	%
Oak Redwoods	28224	4609	16%	983	3%	2341	8%
Holly Redwoods	21670	3640	17%	964	4%	2565	12%
Baswich Stafford	38801	5720	15%	1246	3%	1221	3%
Bromley Stafford	24469	5541	23%	1637	7%	907	4%
GB East Wing Tamworth	24899	6582	26%	2422	10%	1705	7%
Core service total	**138062**	**26092**	**19%**	**7251**	**5%**	**8739**	**6%**
Trust Total	**1847533**	**220632**	**12%**	**78422**	**4%**	**38181**	**2%**

This core service had 6.6 (4%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
George Bryan Centre	GB East Wing Tamworth	25.7	2.0	8%
Redwoods Centre	Holly Redwoods	31.9	1.8	6%
St Georges Hospital	Baswich Stafford	40.7	1.8	5%
Redwoods Centre	Oak Redwoods	33.1	1.0	3%
St Georges Hospital	Bromley Stafford	28.1	0.0	0%
Core service total		**159.4**	**6.6**	**4%**
Trust Total		**5109.7**	**679.3**	**14%**

The sickness rate for this core service was 7.4% between 1 October 2017 and 30 September 2018. The most recent month's data (30 September 2018) showed a sickness rate of 6.2%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % staff sickness (over the past year)
St Georges Hospital	Bromley Stafford	13.7%	9.3%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % staff sickness (over the past year)
Redwoods Centre	Holly Redwoods	7.3%	8.7%
Redwoods Centre	Oak Redwoods	2.9%	8.4%
George Bryan Centre	GB East Wing Tamworth	2.3%	7.8%
St Georges Hospital	Baswich Stafford	5.3%	4.0%
Core service total		**6.2%**	**7.4%**
Trust Total		**4.7%**	**5.2%**

The below table covers staff fill rates for registered nurses and care staff during September 2018, October 2018 and November 2018.

Baswich ward had below 90% of the planned registered nurses for night shifts in September 2018 and day time care staff in October 2018. This ward also had over 125% fill rate for day time registered nurses for the three-month period.

Bromley Ward had over 125% fill rate for day and night time care staff for the three months.

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 (%)
	September 2018				**October 2018**				**November 2018**			
Holly	91.1	101.9	92.5	120.0	96.5	97.3	95.2	129.5	99.8	91.9	100.0	123.3
Oak	109.6	93.5	97.1	140.5	109.2	101.9	92.3	154.8	107.2	91.6	102.1	123.3
Baswich	134.4	99.3	88.0	158.6	149.7	83.1	100.8	152.1	150.9	99.9	98.5	212.0
Bromley	92.4	138.5	97.5	194.6	99.0	121.0	98.8	133.1	97.5	125.5	100.5	170.6
GB East Wing	110.0	129.7	123.2	135.2	101.7	106.4	117.9	119.4	114.7	106.7	123.9	102.0

Medical staff

Between 1 October 2017 and 30 September 2018, of the (9,298) total working hours available, none were filled by bank or agency staff to cover sickness, absence or vacancy for medical locums.

Ward/Team	Total hours available	Bank Usage		Agency Usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
ISFOP GB East Wing Tamworth	1958	0	0%	0	0%	0	0%
ISFOP Baswich Stafford	1468	0	0%	0	0%	0	0%
ISFOP Bromley Stafford	1958	0	0%	0	0%	0	0%
IDEM Oak Redwoods	1958	0	0%	0	0%	0	0%
IFNCT Holly Redwoods	1958	0	0%	0	0%	0	0%
Core service total	9298	0	0%	0	0%	0	0%

Ward/Team	Total hours available	Bank Usage		Agency Usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Trust Total	396315	2237	1%	38147	10%	1680	0%

Mandatory training

The compliance for mandatory and statutory training courses at 30 November 2018 was 90%. Of the training courses listed, eight failed to achieve the trust target and of those, none failed to score above 75%.

The trust set a target of 90% for completion of mandatory and statutory training. The trust reports training on a month by month rolling basis.

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
Health and Safety (Slips, Trips and Falls)	33	33	100%	✓
Manual Handling - Object	9	9	100%	✓
Corporate Induction	33	33	100%	✓
Promoting Safer and Therapeutic Services	155	153	99%	✓
Local Induction	164	158	96%	✓
Equality and Diversity	164	158	96%	✓
Mental Capacity Act Level 2	157	149	95%	✓
Safeguarding Children (Level 2)	164	155	95%	✓
Safeguarding Adults (Level 1)	164	154	94%	✓
Adult Basic Life Support	155	144	93%	✓
Conflict Resolution	11	10	91%	✓
DMI - Foundation Violence & Aggression	150	137	91%	✓
Fire Safety - 1 Year	164	150	91%	✓
Fire Safety Instruction & Evacuation - Level 3	151	134	89%	✖
Prevent Awareness	164	144	88%	✖
Medicine management training	76	65	86%	✖
Infection Prevention (Level 1)	157	131	83%	✖
Clinical Risk Assessment	92	75	82%	✖
Information Governance	164	133	81%	✖
Manual Handling - People	155	122	79%	✖
Mental Health Act	85	64	75%	✖
Total	**2567**	**2311**	**90%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff carried out a risk assessment for every patient on admission and updated it regularly, including after any incident. We looked at 26 patient care records during this inspection. We found that staff assessed individual patient risks in each of the records we examined.

Staff used a recognised risk assessment tool and worked with members of the multidisciplinary team to assess risks associated with a patient's physical health.

Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers.

Staff identified and responded to changing risks to, or posed by, patients. For example, patients admitted from or returning from treatment in an acute hospital were nursed on increased observation levels.

Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms.

Staff applied blanket restrictions on patients' freedom only when justified.

Staff adhered to best practice in implementing a smoke-free policy. For patients willing to consider it, smoking cessation support was available to them.

Informal patients could leave at will and knew that. The wards displayed information explaining why doors were locked and how patients could leave if they were free to do so.

Use of restrictive interventions

This service had 287 incidences of restraint (167 different service users) and 70 incidences of seclusion between 1 October 2017 and 30 September 2018.
The below table focuses on the last 12 months' worth of data: 1 October 2017 and 30 September 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Baswich	1	47	56	0 (0%)	10 (21%)
Bromley	0	58	23	5 (9%)	4 (7%)
East Wing	0	22	8	2 (9%)	5 (23%)
Holly	0	33	18	8 (24%)	19 (58%)
Oak	3	127	62	0 (0%)	11 (9%)
Total	**4**	**287**	**167**	**15 (5%)**	**49 (17%)**

The trust trained staff in a de-escalation management and intervention programme, aimed specifically at working with older adults. The programme was in the process of being accredited by the British Institute of Learning Disabilities. Staff used restraint only after de-escalation had failed and used correct techniques which included guided walk, arm holds and seated position restraint.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

There were 15 incidences of prone restraint, which accounted for 5% of the restraint incidents. Staff told us they never used prone restraint. The trust explained that whilst staff did not use prone restraint, some patients placed themselves on the floor, so staff recorded these incidents as prone restraint. Staff told us Over the 12 months, incidences of restraint ranged from four per month to 42 per month.

Staff told us that the use of rapid tranquilisation was rare across this service and was used only as a last resort.

There were 49 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from none to 10 over the 12-month period.

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

There have been zero instances of mechanical restraint over the reporting period.

None of the wards had a specific seclusion room and staff told us that secluding patients was very rare on their wards. There have been four instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from none to two per month. The number of incidences (4) was the same as the previous 12-month period (4).

There have been zero instances of long-term segregation over the 12-month reporting period.

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 at risk 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 at risk, 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.

Staff received training in safeguarding, knew how to raise a safeguarding concern, and did that when appropriate.

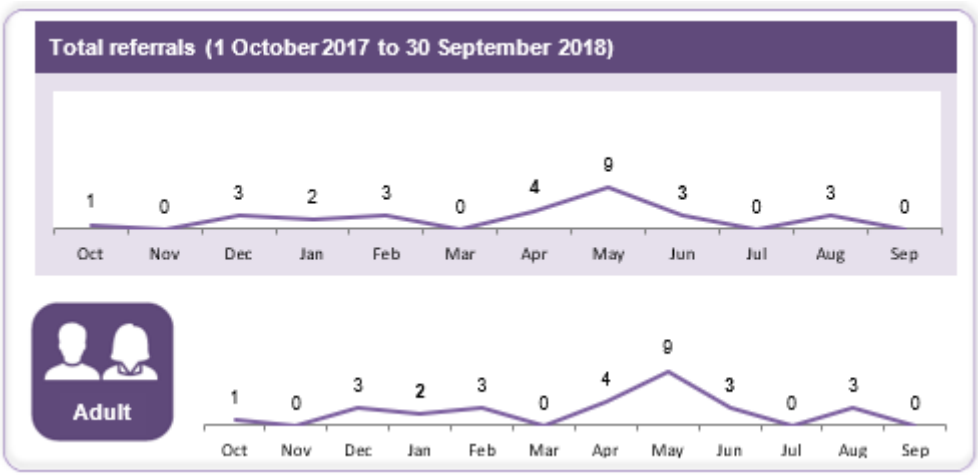
Staff could give examples of how they had protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff followed safe procedures for children visiting the ward.

This core service made 28 safeguarding referrals between 1 October 2017 and 30 September 2018, all of which concerned adults.

The number of adult safeguarding referrals reported in each month ranged from none in November 2017, March 2018, July 2018 and September 2018 and nine in May 2018.



Staff access to essential information

The trust used an electronic patient records system. Information such as individual patient fluid charts and antecedent, behaviour, consequence charts (ABC charts) were scanned into the electronic patient record by administrators in a timely manner. Staff kept paper copies of essential patient information such as personal emergency evacuation plans in case of emergencies, when the electronic record system may not be available to staff. They ensured the paper copies were kept up to date to reflect changing patient needs.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. This included when patients moved between wards and teams.

Medicines management

Staff followed good practice in medicines management. This included transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication. Medicines management was in line with national guidance.

Staff regularly reviewed the effects of medication on patients' physical health and in line with the National Institute for Health and Care Excellence (NICE) guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Staff carried regular audits with respect to the prescribing of medicines. We found no evidence to indicate that staff used medication as a first line response to deal with dementia related behaviours. The service had updated junior doctor training to ensure they understood the need for behaviour management plans to be explored and developed before the prescribing of medicines.

Track record on safety

Between 1 October 2017 and 30 September 2018 there were eight serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'slips / trips / falls' with four.

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 eight 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.

	Number of incidents reported					
Type of incident reported (SIRI)	Slips / Trips / Falls	Apparent/actual/suspected self-inflicted harm	HCAI/Infection control incident	Pressure ulcer	Pending review	**Total**
Oak	2	-	-	1	-	**3**
Bromley	-	1	1	-	-	**2**
Baswich	-	-	-	-	1	**1**
East Wing	1	-	-	-	-	**1**
Holly	1	-	-	-	-	**1**
Total	**4**	**1**	**1**	**1**	**1**	**8**

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. They told us the electronic reporting system was accessible and easy to use.

Staff reported all incidents that they should report. Things they needed to report included falls, pressure ulcers and patient aggression.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if, and when, things went wrong.

Most staff said they received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback in team meetings and in supervision.

We saw examples of changes the service had introduced following incident reporting. This included conducting a thematic review of falls between 2016-17 and subsequent changes to falls risk assessments.

Most staff said they received a debrief and received support after a serious incident. Although some staff said whilst their direct line managers were very supportive, senior trust leaders had not given them due recognition or support following serious incidents.

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 five 'prevention of future death' reports sent to the trust, none of which related to this service.

Is the service effective?

Assessment of needs and planning of care

We looked in detail at 26 patient care records across this service. They were good quality records, demonstrating that staff understood the importance of clear, thorough recording.

Staff completed a comprehensive mental health assessment of the patients in a timely manner during, or soon after, admission. Allied health professionals completed their assessments soon after admission. Staff used recognised assessment tools including Addenbrooke's Cognitive Assessment (ACE), Beck's Depression Inventory and Functional Analysis of Care Environments (FACE) risk assessment for older adults.

Staff assessed patients' physical health needs in a timely manner after admission. However, staff told us that there could be delays in clinicians receiving the outcome of blood tests. This was because the trust did not enable clinicians to have direct access to test results. To access test results in a timely manner, clinicians relied upon GP trainees who were on placement with them, because the trainees had access rights based on their educational status, which trust clinicians did not. If there was no trainee GP or the trainee was not available, other staff had to chase the results and await their receipt via the postal service. Staff told us this could cause unnecessary delays to diagnose and plan suitable treatment options. However, the trust told us that test results could be accessed in a timely manner either via the electronic system or by direct contact with the pathology lab.

Staff developed care plans that met the needs identified during assessment. These linked clearly with identified patient risk and need. Staff on Oak Ward risk assessed, and care planned for empathy dolls for patients they believed would benefit. Empathy dolls are believed to reduce agitation and restlessness for some people with dementia.

Care plans were personalised and holistic. For patients with a functional mental illness they were also recovery-oriented. For patients with an organic mental illness, care plans were strengths and support based.

Staff routinely updated care plans when necessary.

Best practice in treatment and care

This service did not participate in any national clinical audits as part of their clinical audit programme 2017 - 2018.

Clinical audit is a process that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria, to then implement change based on the findings. It is a mechanism for quality improvement. Whilst this service did not participate in any nationwide clinical audit programme, both the medicines management team and local ward managers carried out regular audits. These included the prescribing of antipsychotics, prescribing of hypnotics, quality of care records and ward based medicines management processes.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medication and psychological therapies, activities and opportunities intended to help patients regain independent living skills. Patients had access to psychological therapies including individual psychology and cognitive stimulation therapy. Cognitive stimulation therapy is recommended by the National Institute for Health and Care Excellence and has numerous benefits including increased confidence, language and mood for people in the mild to moderate stages of dementia.

Each patient was assessed and provided with an occupational therapy and physiotherapy programme based upon their individual strengths and needs. To assess and plan individual patient therapy programmes, the service used recognised assessment tools including, The Vona du Toit Model of Creative Ability (Vdt MoCA), The Model of Human Occupation Screening Tool (MOHOST) and the Large Allen Cognitive Level Screen (LACLS). The ward based occupational therapy and physiotherapy teams worked closely together to integrate their therapy programmes. The nursing teams worked alongside therapy colleagues to implement these individual plans outside of dedicated therapy sessions. This provided a whole team approach to supporting patients with their assessed needs. Patients each had a mobility prescription chart in their bedrooms to identify any mobility aids the patient required for self or supported mobilising.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff had received additional training to support them to identify and manage physical health issues such as delirium, dehydration, risks to skin integrity and sepsis. One carer told us that staff on Baswich Ward had identified sepsis very quickly, which the carer was certain had saved the patient’s life. Staff had speedy access to equipment frequently used in acute and community health trusts to diagnose common conditions in this patient group, such as bladder scanners. Providing patients with access to specialist diagnostic equipment without having to leave the ward was particularly helpful for patients living with dementia because it supported them to remain well-oriented and reduced potential agitation.

Staff assessed and met patients’ needs for food and drink and for individual nutrition and hydration regimes. The trust employed speech and language therapists and dietitians who were linked to the wards in this service, which meant patients had speedy access to specialist assessment and treatment.

Staff supported patients to live healthier lives – for example, through participation in smoking cessation schemes, healthy eating advice and managing cardiovascular risks. Ward based therapy programmes integrated healthy lifestyles into the wider therapeutic programme. Depending upon their individually assessed needs and strengths, patients could participate in cooking, walking, dance, praxis and balance sessions or seated exercise. The trust had an active Arts for Health team who led numerous activities across the service including reading for well-being, dance and creative writing. Baswich and Bromley wards worked with a local onsite nursery to run regular intergenerational sessions. Patient comments relating to this programme were very positive. The sessions engaged patients, staff and nursery children in a planned activity. The

service also paid for regular PAT (Pets as Therapy) dog visits and live music sessions on the wards. Wellbeing therapies, such as hand and head massage, were also available. The service provided a wide range of therapeutic activities for patients including gardening, baking, t-shirt printing, craft sessions and concerts in conjunction with local community groups.

Staff used recognised rating scales to assess and record severity and outcomes, including Health of the Nation Outcome Scales (HoNOS).

Staff used technology to support patients effectively. The service held licences for dementia specific, evidence based, digital therapy systems. Systems of this type have been shown to support patients to reduce heightened levels of agitation and distress. Families could record messages of comfort, love and guidance for their relative, which staff played when patients needed support to self soothe. Patients could access ward based WiFi, if they used their own devices, or could use a ward based computer to access the local Recovery College.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. Staff had been involved in a number of rapid process improvement workshops, supported by the trust's quality improvement programme. They were able to generate interest for new ideas and share findings in ward based team huddles and team meetings. Staff were supported to work toward accreditation schemes for their wards, such as the Royal College of Psychiatrists' Quality Network for Older Adults Mental Health Services (QNOAMHS, which was formally known as AIMS-OP). However, staff at George Bryan Centre East Wing told us the trust had not supported them to work towards the accreditation.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 90%. 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 97% (as at 30 November 2018).

The wards with the lowest appraisal rate at 31 March 2018 were 'Bromley Stafford' with 70%, 'Holly Redwoods' with 83% and 'George Bryan East Wing with 86%.

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 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
Baswich Stafford	36	35	97%	94%
Oak Redwoods	28	28	100%	93%
GB East Wing Tamworth	25	22	88%	86%
Holly Redwoods	30	30	100%	83%
Bromley Stafford	24	24	100%	70%
Core service total	**143**	**139**	**97%**	**86%**
Trust wide	**4490**	**3615**	**81%**	**88%**

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff within this service was 80%. This year so far, the overall appraisal rates this was 100% (as at 30 November 2018).

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
Baswich Stafford	0	0	N/A	100%
Bromley Stafford	1	1	100%	100%
Oak Redwoods	1	1	100%	100%
Holly Redwoods	1	1	100%	100%
GB East Wing Tamworth	1	1	100%	0%
Core service total	**4**	**4**	**100%**	**80%**
Trust wide	**137**	**77**	**56%**	**80%**

The trust was not able to provide any data around clinical supervision. However, during the inspection, staff and managers told us that all staff received a mix of both clinical and managerial supervision. We looked at supervision rates and found they were high. Clinical supervision was provided through a variety of outlets including one to one, group, and peer based. For staff without professional qualifications, there were opportunities to engage in psychology-led reflective practice sessions. Managers also provided staff with managerial supervision (these are meetings to discuss case management, to reflect on and to learn from practice, and for personal support and professional development).

Managers provided staff with annual appraisals of their work performance. Managers ensured that staff had access to regular team meetings. We looked at team meeting minutes and found they covered important ward business and well attended by staff.

The trust was not able to provide any data around clinical supervision for medical staff.

The service included the full range of specialists required to meet the needs of patients on the ward. These included doctors and nurses, health care support workers, physiotherapists and occupational therapists, clinical psychologists and assistant psychologists, pharmacists and pharmacy technicians, speech and language therapists, dieticians and activity coordinators. Holly Ward and Oak Ward also had a service user representative and a volunteer supporting them. Baswich and Bromley wards had a discharge liaison officer based on the wards.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff on all the wards had completed the trust's online dementia training programme. Senior clinicians also delivered regular training sessions for staff considering mental health in older people and less common forms of dementia.

Managers provided new staff with an appropriate induction and shadowing opportunities. These included routine orientation to the working environment and to the patient group.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. The trust listened to staff and supported them to develop in new roles to meet the needs of patients and the service.

Managers ensured that staff received the necessary specialist training for their roles. Health care support workers could work towards the Care Certificate and train to perform ECGs and venepuncture for patients. Nursing staff were able to train as non-medical prescribers.

Managers dealt with poor staff performance promptly and effectively. The trust had a human resources department, which supported local managers with this process.

The trust supported local managers on Holly ward to recruit and retain a volunteer who supported patients with a regular bingo session.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. We observed one meeting and looked at patient records containing evidence of these meetings. The meetings were thorough and considered all aspects of the patient's risk, need and goals.

Staff shared relevant information about patients at effective shift handover meetings and in daily team huddles. Staff used "patient at a glance boards" to record essential patient information, which could be seen quickly.

The ward teams had strong and effective working relationships, including good handovers with each other and with other relevant teams across the organisation, such as community mental health teams when planning for patient discharge.

The ward teams had effective working relationships with teams outside the organisation. We met with one visiting local authority social worker who informed us that the ward had provided the necessary information to enable a social care assessment to commence for the patient and had invited them to be part of a discharge planning meeting.

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

As of 30 November 2018, 75% 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 for inpatient and all community staff and was renewed three years.

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

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 and how to contact them.

The provider had the 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.

Patients had easy access to information about independent mental health advocacy. Staff displayed posters and leaflets, so patients could access the information. Staff referred patients to the advocacy service if the patient did not have the mental capacity to understand that a referral would be in their best interests.

Staff explained to patients what their rights were under the Mental Health Act, in a way they could understand. If patients did not understand, staff would return and repeat the information until the patient could understand. Staff recorded in patients' records when they had done this.

Staff ensured that patients detained under the Mental Health Act were able to take Section 17 leave when it had been granted (this is permission for detained patients to leave hospital).

Staff requested an opinion from a second opinion appointed doctor when necessary. Staff recorded requests for second opinion doctors in patients' records and recorded if there were any delays.

Staff stored copies of patients' detention papers and associated records safely and effectively, so that they were available to all staff that needed access to them. These included Section 17 leave forms and Approved Mental Health Professional reports.

The service displayed a notice to tell informal patients that they could leave the ward freely.

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 (if applicable).

Staff carried regular audits to ensure that the Mental Health Act was being applied correctly.

Good practice in applying the Mental Capacity Act

As of 30 November 2018, 95% of the workforce in this service had received training in the Mental Capacity Act Level 2. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The trust told us that 63 Deprivation of Liberty Safeguards (DoLS) applications were made to the Local Authority for this service between 1 October 2017 and 30 September 2018.

The greatest number of DoLS applications were made in July 2018 with 10.

CQC received 129 direct notifications from the trust between 1 October 2017 and 30 September 2018.

	Number of 'Standard' DoLS applications made by month (Trust data)												
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	**Total**
Standard applications made	7	9	2	5	4	6	7	4	3	10	2	4	**63**
Standard applications approved	4	3	1	2	0	2	3	1	0	1	1	0	**18**

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles and were able to give examples of applying these is their roles.

The trust had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. 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, including Deprivation of Liberty Safeguards.

Staff took all practical steps to enable patients to make their own decisions. Staff on Baswich Ward had a hand held wipe board to support communication with patients. Medical staff told us the multidisciplinary team supported patients with decision making and best interests' decisions.

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. Examples of decision specific issues included agreeing to blood tests.

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

Staff understood restraint within the meaning of the Act and knew when to apply for authorisation of a Deprivation of Liberty. Staff made Deprivation of Liberty Safeguards applications when required and monitored the progress of applications to supervisory bodies. Staff told us the trust kept a log of all referrals made to the Supervisory Body.

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

Staff audited the application of the Mental Capacity Act.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at all three service locations scored higher than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Other specialist services Secure wards / Forensic inpatient Wards for older people with mental health problems	98.9%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units Wards for older people with mental health problems	92.1%
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	96.2%
Trust overall		**96.9%**
England average (mental health and learning disabilities)		**91.0%**

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing 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.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. The occupational therapy team were able to offer outreach support to patients to support them with building links in their community in readiness for their discharge.

Patients said staff treated them well and behaved appropriately towards them. One patient told them a member of staff could be rude at times, but they had spoken to the member of staff about this.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. When patients required support to meet their cultural and spiritual needs, staff supported them in line with their wishes.

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 used the admission process to inform and orient patients to the ward and to the service. Patients were given a “welcome pack”, which contained essential and useful information about their hospital stay, the therapy programmes and issues the patient may wish to discuss at their discharge planning meetings.

Staff involved patients in care planning and risk assessment. We found evidence of this in care plans, family and patient ward meetings and by talking with patients and their families. Records showed that staff offered patients a copy of their care and support plan, but most patients declined to receive a copy.

Staff involved patients and their families to use technological solutions to promote wellbeing in the hospital environment. These included the use of the individualised electronic support tools to help patients recall memories, create life history work and facilitate reminiscence therapy sessions.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. If families were unable to help, staff supported patients to access the local audiology service if they needed an assessment or if their hearing aids were lost or broken. Staff were able to use communication tools suited to the needs of individual patients, such as pictures and symbols or electronic verbal messages of comfort that family could record. Baswich Ward also kept a handheld wipe board which they could use to communicate with patients. They also developed personal behaviour support plans for patients to take with them when they were discharged. Staff said feedback from local care homes about these plans was very positive, because it helped care home staff to interpret their resident's behaviour effectively. Staff on Oak Ward supported patients to make picture memory books, which they were encouraged to take with them when they were discharged. One patient showed us the book they had made, which demonstrated the strengths-based work they had done to develop their gardening skills while they were on the ward.

Staff involved patients when appropriate in decisions about the service. Patients were encouraged to give feedback by using forms contained in the welcome pack, by attending one of the community meetings or by speaking with the PALS team (the patient advice and liaison service).

When appropriate, staff enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) and supported patients and families to consider DNACPR arrangements.

Staff ensured that patients could access advocacy services, referring patients who did not have the mental capacity to understand that they were in need of an advocate. Staff displayed leaflets and posters for patients advertising the generic advocacy, the independent mental health advocacy and the independent mental capacity advocacy service. The welcome packs also contained information about advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. We spoke with 16 family members and carers to obtain their views about their relatives care and hospital stay. Almost all were positive about how they had been involved in their relative's care. However, one family told us they felt staff used too many abbreviations, feeling communication could be improved if staff used plain English and another family told us they had not been kept informed about their relative's progress, which they were angry about, but we found there were clinical reasons for this. All the other carers and family members we spoke with were positive about the service and praised the ward staff for their efforts.

Staff provided carers with information about how to access a carer's assessment. The ward welcome packs contained useful information for carers about local support services available in the community and national helplines.

The welcome packs contained information for carers about the therapy programmes and how to interpret the programmes to best meet the needs of their relative.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for all five wards in this service between 1 October 2017 to 30 September 2018.

All five of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period. Oak Ward were involved in a locally led hospital avoidance programme. This had been reviewed since the introduction in 2016 and showed year on year reductions in occupied bed days and length of stays for patients.

Ward name	Average bed occupancy range (1 October 2017 – 30 September 2018) (current inspection)
Bromley Stafford	84.3% - 101.9%
GB East Wing	84.2% - 99.4%
Holly Redwoods	76.4% - 101.0%
Baswich Stafford	66.1% - 100.0%
Oak Redwoods	45.0% - 87.3%

Beds were available when needed for patients living in the 'catchment area'. However, George Bryan Centre East Wing was in the process of preparing for a temporary closure at the time of our inspection, which meant patients in the Tamworth area would need to travel 30 miles to St George's Hospital in Stafford to receive an inpatient service.

There was always a bed available when patients returned from leave. Patients did not lose their bed if they went home on overnight leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.

When patients were moved or discharged, this happened at an appropriate time of day.

The trust provided information for average length of stay for the period 1 October 2017 to 30 September 2018.

Ward name	Average length of stay range (1 October 2017 – 30 September 2018) (current inspection)
Baswich Stafford	11.7 – 150.5
GB East Wing	31.5 – 140.0
Bromley Stafford	31.5 – 131.0
Oak Redwoods	38.5 – 87.5
Holly Redwoods	29.1 – 78.4

This service reported no out of area placements between 1 January 2018 and 30 September 2018.

This service reported 23 readmissions within 28 days between 1 October 2017 and 30 September 2018. Fourteen of the readmissions (61%) were readmissions to the same ward as discharge. The average of days between discharge and readmission was 14 days. There were four instances whereby patients were readmitted on the same day as being discharged and there were none where patients were readmitted the day after being discharged. Oak Ward told us that patients being readmitted post discharge had reduced since the introduction of the hospital admission avoidance programme.

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
Holly	8	7	88%	0 – 28	17
Baswich	6	3	50%	0 – 20	10
Bromley	4	1	25%	11 – 21	16
GB East Wing	3	1	33%	0 – 25	16
Oak	2	2	100%	0 – 26	13

Discharge and transfers of care

Between 1 October 2017 and 30 September 2018 there were 326 discharges within this service. This amounts to 8% of the total discharges from the trust overall (3682).

Ward name	Number of discharges	Number of delayed discharges	% Delayed
Baswich	43	8	19%
Bromley	54	10	19%
Oak	77	6	8%
Holly	105	3	3%
GB East Wing	47	0	0%
Total	**326**	**27**	**8%**

Staff planned for patients' discharge from early in the admission and the pathway was clear for patients and families. Staff liaised with care managers/co-ordinators and supported patients to apply for Continuing Health Care where necessary. Bromley and Baswich wards shared a full-time discharge liaison officer. Their role was to support the discharge process for each patient, taking the lead in liaison between the ward, the local authority and relevant community teams for the patient. Staff reported that since the introduction of the discharge liaison officer post, patient length of stay had reduced by over 40% between January 2018-2019.

Discharge was never delayed for other than clinical reasons. Delays in patient discharge arose in the main due to local authority delays in allocating a social care professional to support the discharge or while state funding was being approved.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

The service complied with transfer of care standards (for example, those set in the National Institute for Health and Care Excellence - Transition Between Inpatient Hospital Settings and Community or Car Home Settings for Adults with Social Care Needs, November 2015).

Facilities that promote comfort, dignity and privacy

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the three locations scored higher than similar trusts.

Site name	Core service(s) provided	Ward food
St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Other specialist services Secure wards / Forensic inpatient Wards for older people with mental health problems	95.6%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units Wards for older people with mental health problems	96.0%

Site name	Core service(s) provided	Ward food
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	93.5%
Trust overall		**94.9%**
England average (mental health and learning disabilities)		**92.2%**

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories.

Patients could personalise bedrooms if they wished to. Staff supported patients to do this and included things the patient found comforting, such as pictures of family and pets.

Patients had somewhere secure to store their possessions. Valuables could be locked away.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. Each ward had sufficient rooms and space to provide a therapeutic environment for patients. George Bryan East Wing had a reminiscence room and conservatory for patients to use for reminiscence. There was a pub style bar with a piano along with a library and dining area. Oak Ward had a set of “pop up” reminiscence surroundings they could use interchangeably. Each ward had a fully equipped clinic room and space to carry out patient examinations in private.

There were quiet areas on the ward and a room where patients could meet visitors.

Patients could make a phone call in private and many had their own mobile phones.

Patients had access to outside space. Each ward had a large safe garden area for patients to use. Bromley and Baswich wards shared a large courtyard garden where staff had arranged raised beds, sensory planting, circular walking areas and plenty of spaces to sit in the sun or shade. Oak Ward had been working with patients to design a gazebo for the garden, using money donate by a relative. The garden had circular walk paving, sensory shrubs and a number of bird feeders and ample seating for patients and visitors. The garden at George Bryan Centre East Wing was spacious but lacked the character and the dementia friendly design of the others.

Patients had access to hot and cold hot drinks and snacks 24/7.

Patients’ engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. Bromley and Baswich wards had an occupational therapy assistant who provided community outreach for patients approaching discharge. Occupational therapy staff across the service carried out home visit assessments with patients to consider their post discharge needs. Ward staff also supported patients to access opportunities at the Recovery College if they willing and able to.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. All the patients we asked told us that staff supported them to maintain contact with their families and carers.

Meeting the needs of all people who use the service

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the three locations scored higher than similar trusts for the environment being dementia friendly and for the environment supporting those with disabilities.

Site name	Core service(s) provided	Dementia friendly	Disability

St Georges Hospital	Acute wards for adults of working age and psychiatric intensive care units Other specialist services Secure wards / Forensic inpatient Wards for older people with mental health problems	98.1%	98.1%
George Bryan Centre	Acute wards for adults of working age and psychiatric intensive care units Wards for older people with mental health problems	95.3%	95.4%
Redwoods Centre	Acute wards for adults of working age and psychiatric intensive care units Secure wards / Forensic inpatient Wards for older people with mental health problems	99.0%	99.0%
Trust overall		**98.1%**	**98.1%**
England average (Mental health and learning disabilities)		**88.3%**	**87.7%**

The service made adjustments for patients with mobility and communication needs – for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs. The service used dementia friendly signage, which incorporated simple wording and pictures to identify ward areas such as bathrooms, toilets and dining rooms. Good signage can promote confidence and independence for patients. Baswich Ward also had handmade tactile signs on the wards. All the wards displayed up to date staffing information for patients and carers, so they could see photographs of the staff on duty. All the wards had bathing and toilet facilities for wheelchair users and people with restricted mobility. Each ward had a supply of suitable hoist slings. However, Bromley Ward had struggled to replenish slings because the trust procurement department were reluctant to supply them. This caused unnecessary work and delay for the ward staff.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain and prescribed medicines. The medicines management team offered patients one to one meetings to discuss their medication. We saw ward staff obtaining medicines information leaflets for patients during the inspection.

The information provided was in a form accessible to individual patients. Ward staff devised easy read style leaflets and posters for patients with limited communication. Baswich ward had a hand-held wipe board to support communication. Each ward had communication cards they could use if appropriate. Staff told us that the speech and language therapists worked mainly with patients at risk of choking but could be engaged to support with communication for patients if required. Some patients were admitted with a "This is Me" document, which staff used to support communication. We observed staff arranging for a patient to have an audiology appointment during the inspection because their hearing aid was not functioning properly.

Staff made information leaflets available in languages spoken by patients.

The trust provided easy access to interpreters and/or signers for patients who required them.

Patients had a choice of food to meet their religious and ethnic dietary requirements. Oak Ward provided "graze boxes" for patients who were nutritionally compromised, and we saw that these were vegetarian and vegan for individual patients. One patient told us they wanted more than one vegetarian option on the lunch menu, but they had not told ward staff about this request. All other patients we asked told us their dietary requirements were well catered for and many had praise for the quality of food available and the portion sizes.

Staff ensured that patients had access to appropriate spiritual support if they wanted it. Spiritual and pastoral support was available from the chaplaincy service. All the wards had easy access to a multi-faith room. The chaplaincy could arrange religious services and meetings with faith leaders

for patients when requested. Patients were also encouraged to use community religious meeting places if appropriate.

Listening to and learning from concerns and complaints

This service received one complaint between 1 October 2017 and 30 September 2018. This complaint related to patient care and was not upheld.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Bromley Ward	1	0	0	1	0	0	0	0

This service received 48 compliments during the last 12 months from 1 October 2017 to 30 September 2018 which accounted for 0.5% of all compliments received by the trust.
Ward based welcome packs contained information explaining how patients and families could make a complaint or raise a concern. Each ward displayed the complaints procedure and information posters and leaflets explaining how to make a complaint. Ward staff also displayed CQC posters advising patients how to share their experience of their care. Most patients told us they were not sure how to complain but they did feel confident they would raise a concern with a member of staff if they did have an issue. They were confident that if they did raise an issue they would be listened to.

When patients raised concerns in a community meeting, they received feedback and the issue was documented in the meeting minutes.

Staff told us they would protect patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately but said they had very few complaints and they would probably need to check the policy and procedure.

Is the service well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Staff teams were complimentary about, and supportive of, their local ward managers.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. They each showed passion and commitment in their role, toward both patients and staff.

Leaders were visible in the service and approachable for patients and staff.

Leadership development opportunities were available, including opportunities for staff below ward manager level. New roles had been introduced to compliment the multidisciplinary team, including advanced practitioner consultant nurse and non-medical prescriber to some wards.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

Most staff felt they had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. However, some staff felt the trust was slow to communicate important decisions such as the future of some wards.

Staff could explain how they were working to deliver high quality care within the budgets available. Staff on some wards were involved in "Discharge to Assess" and "Hospital Avoidance" schemes. They were proud of the positive impact these schemes had both on patient care and on budget saving measures.

Culture

Staff felt respected, supported and valued by their immediate line managers. Several staff noted times when senior leaders within the trust had visited their ward and said the experience had helped them to feel valued and listened to by senior leaders. However, a number of staff on one ward felt that senior leaders within the trust had not supported them when they most needed it.

Staff felt positive and proud about working for the trust and their team. Without exception, staff expressed their enthusiasm and commitment to their role, their team and their patients.

All but one member of staff felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed and had guidance from the human resources team to support them with this.

Teams worked well together and expressed positivity and respect for their multidisciplinary team colleagues.

Staff appraisals included conversations about career development and how it could be supported. Some staff told us about their positive development journeys within the trust. There were development opportunities for health care support workers to train as nursing associates and for registered nurses as nurse consultants and non-medical prescribers.

The service's staff sickness and absence rates were roughly 2% higher than the trust average.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff told us their line managers were a source of support and understanding when they needed it.

The trust recognised staff success within the service, holding award ceremonies. Staff proudly displayed the awards their teams had won.

Governance

Each ward had suitable governance systems in place to ensure the safe and effective running of the ward. Ward managers ensured that staff held lead roles for specific areas such as carer engagement, infection prevention and control, care plan audits and Mental Health Act audits. The ward manager had oversight of these roles and the ward audit programme.

The trust safer staffing tool worked well for managers, but they retained authority to increase staffing levels based on patient acuity and ward activity.

The trust incident reporting system was easy for staff to use and they knew what to report. Managers had oversight of all incident reporting and key issues were discussed with staff in team

meetings and team huddles. The huddles gave managers the opportunity to share key information with staff about the ward on a daily basis, outside of shift handover.

The trust's learning and development system gave staff reminders of when their mandatory training was due for renewal and managers had oversight of this along with local supervision and appraisal rates. Appraisal rates were high, higher than the trust average. George Bryan Centre East Wing had introduced a registered general nurse to the team and other wards were considering this as a means of countering recruitment difficulties and supporting the provision of physical health care for patients.

The trust gave sufficient autonomy to local ward managers to engage in improvement initiatives, which had a positive impact on patient care. These included the hospital admission avoidance team, the discharge to assess beds programme, developing a community outreach occupational therapy assistant role and increasing the numbers and working hours of activity coordinators on the wards.

There was a clear 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 across the service.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding concerns at the service level.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

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

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward level. Staff at ward level could escalate concerns when required.

Staff concerns matched those on the risk register.

The service had plans for emergencies including adverse weather and fire.

Where cost improvements were taking place, they did not compromise patient care. The impact of any cost improvement on the quality of care was always assessed and reviewed.

Engagement

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

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. Staff told us the patient record system worked well for them, was easy to use and generally reliable.

Information governance systems included confidentiality of patient records. Staff were clear on their information governance responsibilities. They were clear with patients with respect to how they kept patient information safe. Welcome packs provided information to patients about how their information would be stored and used.

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.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. The service adjusted the format of information for staff with dyslexia.

Staff made notifications to external bodies as needed, including the local authority and CQC.

Learning, continuous improvement and innovation

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used – for example, through the intranet, bulletins, newsletters and community meetings

Patients and carers had opportunities to give feedback about the service they received in a manner that reflected their individual needs. Staff worked with the trust and patient carers to design a palliative care suite on Baswich Ward. This was in response to a growing demand for patients reaching the end of their lives to be supported by their family carers on the ward. Building work to reconfigure the suite was underway during our inspection. Staff on Oak Ward had purchased a temporary bed for carers to use when they wanted to support their relative on the ward at the end of their life.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Directorate leaders engaged with external stakeholders – such as commissioners, CQC and local Healthwatch groups. Oak Ward was working with local commissioners to develop discharge to assess beds and the hospital admission avoidance programme. The combination of these programmes meant that admissions to the ward had significantly reduced. At the time of our inspection, only half of the beds were occupied. The discharge liaison officer role on Baswich and Bromley wards was credited with reducing patient stays by over 40% in the last year.

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.

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**
Quality Network for Older Adults Mental Health Services (QNOAMHS, which was formally known as AIMS-OP	Holly Ward – Redwoods (February 2016) Oak Ward – Redwoods (March 2018)

Wards for people with a learning disability or autism

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Oak House, Mytton Oak, Royal Shrewsbury Hospital	Oak House	10	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 this service safe?

Safe and clean environment

Safety of the ward layout

Staff at the service assessed and managed risk well. They carried out regular risk assessments of the care environment. Managers carried out environmental risk assessments annually. Environmental assessments encompassed risks relating to disability and mobility to reduce the risk to the patient group.

The ward layout allowed staff to observe all parts of the ward. There were always staff members in communal areas with patients and there were clear lines of sight to both bedroom corridors.

There were ligature risks on Oak House. Details can be found below.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Oak House	Whilst some risks are evident on this ward, the patient group means the risks here are low as the patients on this ward have complex needs and require a high level of observation and engagement.	No	Mitigation plan completed. Staff observations and engagement form this plan, and control measures are put in place as required. The mitigation plan allows the ward to manage the risks locally.

There were ligature points, but due to the complexity of patient needs, this was managed through individual risk assessments, observations and engagement with patients.

Over the 12-month period from 1 October 2017 to 30 September 2018 there were no mixed sex accommodation breaches within this service. All patients had a single bedroom with males residing in one corridor and females in the opposing corridor. All toilet areas were gender specific. There was only one useable bathroom in the service, which was located in the middle of the ward area. The other bathroom was not deemed fit for purpose, so was out of use. This had no impact on patients as they could use the alternative bathroom. There was a female only lounge and a mixed gender lounge. The therapy room was used for activities and could be mixed gender or single gender, depending upon patient need.

Patients had easy access to nurse call systems. There were nurse alarms located in patient bedrooms and staff carried alarms.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings, were well maintained and ensured the privacy and dignity of patients.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the location scored higher than similar trust's for cleanliness and scored higher than similar trusts for condition, appearance and maintenance.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
Oak House	Wards for people with learning disabilities or autism	99.0%	99.2%
Trust overall		**99.6%**	**99.3%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

Cleaning records were up to date and demonstrated that the ward was cleaned regularly.

Staff adhered to infection control protocols. We observed that hand-washing posters were displayed on noticeboards and in the reception area.

Clinic room and equipment

The clinic room was well equipped with accessible resuscitation equipment and emergency drugs. We saw evidence that this was checked weekly by staff.

Staff maintained equipment well and kept it clean. Clean stickers were visible and in date and all equipment such as beds and hoists had been through portable appliance testing (PAT) within the last 12 months. Basic physical health equipment such as blood pressure machines and thermometers were clean and regularly monitored.

Safe staffing

The service had staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, whilst there were enough skilled nursing staff on every shift, staff told us that only one band 3 healthcare assistant was trained in the use of emergency medicines. On occasion, this prevented patients from accessing community services outside of the hospital grounds, when this member of staff was not on shift, as the qualified nurse would remain on the unit.

Managers had calculated the number and grade of nurses and healthcare assistants required. There was always one qualified nurse and two healthcare assistants on each shift.

The number of nurses and healthcare assistants matched the number of staff on all shifts. We looked at staff rotas and found there to be adequate staffing levels for the service.

The ward manager could adjust the staffing levels daily to take account of case mix. The service closed one in five weekends due to not having enough nursing and medical staff. The service was under review as the building was reverting back to the use of the local acute hospital and active recruitment of staff had been suspended awaiting the review. This had minimum effect on patients and their care.

When necessary, managers deployed bank nursing staff to maintain safe staffing levels. Managers told us that the service was currently in the process of a service review, and therefore unable to recruit into vacant posts. Therefore, bank staff were employed, using the services own pool of staff.

When bank staff were used, those staff received an induction and were familiar with the service. Staff told us that this induction was the same as received by permanent staff, due to the nature of the patient group being worked with.

A qualified nurse was always present in communal areas of the ward. We observed nursing staff in communal areas when patients were present, enabling physical interventions and one to one with named nurses to be carried out.

Staff shortages rarely resulted in staff cancelling leave or ward activities.

Nursing staff

As of 30 September 2018, this core service has reported a vacancy rate for all staff of 33%, 39% for registered nurses and 39% for healthcare assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Oak House	3.7	9.3	39%	3.5	12.4	29%	7.4	22.7	33%
Core service total	**3.7**	**9.3**	**39%**	**3.5**	**12.4**	**29%**	**7.4**	**22.7**	**33%**
Trust total	**140.5**	**1969.7**	**7%**	**146.8**	**1424.0**	**10%**	**536.1**	**5645.8**	**9%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 30 September 2018, of the 15650 total working hours available, 17% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank usage for the wards/teams was staff 'vacancies'.

In the same period, agency staff covered 0% of available hours for qualified nurses and 1% of 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**	**%**
Oak House	15650	2594	17%	0	0%	146	1%
Core service total	**15650**	**2594**	**17%**	**0**	**0%**	**146**	**1%**
Trust Total	**3781640**	**96462**	**3%**	**38953**	**1%**	**25030**	**1%**

Between 1 October 2017 and 30 September 2018, of the 19937 total working hours available, 16% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

The main reason for bank usage for the wards/teams was 'vacancies'. There were a number of vacancies at the service as managers were unable to recruit into posts due to the service review.

In the same period, agency staff covered 0% of available hours and less than 1% of 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**	**%**
Oak House	19937	3189	16%	0	0%	38	<1%
Core service total	19937	3189	16%	0	0%	38	<1%
Trust Total	**1847533**	**220632**	**12%**	**78422**	**4%**	**38181**	**2%**

This core service had no staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Mytton Oak	Oak House	15.3	0.0	0%
Core service total		15.3	0.0	0%
Trust Total		**5109.7**	**679.3**	**14%**

The sickness rate for this core service was 8.5% between 1 October 2017 and 30 September 2018. The most recent month's data (30 September 2018) showed a sickness rate of 4.1%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % staff sickness (over the past year)
Mytton Oak	Oak House	4.1%	8.5%
Core service total		4.1%	8.5%
Trust Total		**4.7%**	**5.2%**

The below table covers staff fill rates for registered nurses and care staff during September 2018, October 2018 and November 2018.

Oak House had above 125% of the planned care staff for night shifts in September 2018.

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 (%)
	September 2018				**October 2018**				**November 2018**			
Oak House	102.5	98.9	106.5	130.2	98.1	102.4	106.4	118.5	98.3	100.5	106.8	123.0

Medical staff

There was adequate medical cover day and night provided by the psychiatric duty system and a doctor could attend quickly in an emergency. The consultant from the community team and his junior doctor provided support to Oak House when necessary.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff had received training and were up to date with the appropriate mandatory training. Managers made time for staff members to carry out any mandatory training that was required. The team had a day booked to complete De-escalation Management and Intervention, moving and handling, fire and basic life support. No patients were to be admitted for respite on that day, to allow all staff to be up to date with their training.

The compliance for mandatory and statutory training courses at 30 November 2018 was 94%. Of the training courses listed, six failed to achieve the trust target and of those, one failed to score above 75%. Medicines management training had a compliance rate of 60%. This had little impact on the service as patients brought their own medication from home. Each patient had a medication card with these medications detailed. There were no errors highlighted during inspection.

The trust set a target of 90% for completion of mandatory and statutory training. The trust reports training on a month by month rolling basis.

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	6	6	100%	✓
Equality and Diversity	14	14	100%	✓
Infection Prevention (Level 1)	14	14	100%	✓
Mental Capacity Act Level 2	14	14	100%	✓
Fire Safety - 1 Year	14	14	100%	✓
Local Induction	14	14	100%	✓
Promoting Safer and Therapeutic Services	14	14	100%	✓
Safeguarding Adults (Level 2)	14	14	100%	✓
Safeguarding Children (Level 2)	14	14	100%	✓
Manual Handling - People	14	13	93%	✓
Adult Basic Life Support	14	12	86%	✗
Information Governance	14	12	86%	✗
Fire Safety Instruction & Evacuation - Level 3	14	12	86%	✗
Prevent Awareness	14	12	86%	✗
Mental Health Act	6	5	83%	✗
Medicine management training	5	3	60%	✗
Total	**199**	**187**	**94%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

Risk assessments were individualised, holistic and included those risks associated with physical health. However, staff did not always update patient risk assessments within six months.

Staff carried out a risk assessment of every patient. We reviewed three patient care records out of the four patients on the ward at the time of inspection. We found that risk assessments were present but were not regularly updated within the service's six-month target. One risk assessment had not been updated in over a year and another was three weeks out of date. However, the risks identified in patient risk assessments were captured effectively in individual care plans, and these care plans were updated every readmission.

Staff took a standardised approach to risk by using a template with a risk indicator score and uploading this into the patient's clinical documents on their electronic record.

Management of patient risk

Staff managed patient risk well. All staff were aware of and dealt with any specific risk issues such as falls and pressure ulcers. All patient specific risk issues were clearly documented in patient care plans with a clear intervention plan in place. These were easy for staff to access.

Staff identified and responded to changing risks posed to or by patients. For example, one of the patient bathrooms was closed as it was not safe for patient use due to issues with the bath. However, patients had use of another bathroom located on the other corridor.

The service did not use blanket restrictions.

Staff adhered to best practice in implementing a smoke free policy.

All patients were informal as the service provided planned respite and were able to leave at their will.

Use of restrictive interventions

This service had no incidences of restraint, seclusion or long-term segregation between 1 October 2017 and 30 September 2018. The service did not use seclusion, restraint or rapid tranquilisation. All staff were trained in De-escalation Management and Intervention (DMI), but staff told us that they never used it. Staff told us that they used de-escalation and redirection techniques when necessary.

Safeguarding

Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply 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 at risk 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 at risk, 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 did not make any safeguarding referrals between 1 October 2017 and 30 September 2018

All staff were trained in safeguarding, knew how to raise a safeguarding concern, and did so when appropriate. Staff told us that they had completed level 2 training and demonstrated a good understanding of safeguarding. Staff we spoke with understood the trust's safeguarding policies and procedures and those of the local authority. There was a head of strategic safeguarding in place and all staff knew who this was.

Staff could give examples of how they had protected patients from harassment and discrimination and received feedback of any lessons learnt.

Staff knew how to identify adults and children at risk or suffering significant harm. This included working with partner agencies. Managers informed us that the service had good working relationships with the local authorities.

Staff followed safe procedures for any children that might visit the ward.

The trust had submitted details of two serious case reviews commenced or published in the last 12 months (1 October 2017 to 30 September 2018). None related to this core service.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, whether paper-based or electronic.

Staff kept records of patients' care and treatment using an electronic patient record. Staff kept paper copies of patient's hospital passports in order to support access to acute services. However,

none of the hospital passports viewed had a photograph of the patient attached. Staff also kept paper copies of essential patient information for times when the electronic system may not be available, during downtime. Staff informed us that this was not a regular occurrence. Staff ensured that paper copies were regularly kept up to date.

All information needed to deliver patient care was available to all relevant staff, when they needed it and was in an accessible form. Patient records were available to all staff (including bank staff) providing care and were clear, up-to-date and contained relevant current and historical clinical information.

Medicines management

Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health. Staff worked with patients who brought in their own medication. Staff counted this in and checked medicines were in date on admission and discharge. Staff stored medicines in cupboards in the clinic room, apart from emergency medication which was stored in the nursing office. Staff monitored the fridge temperature daily.

Staff monitored the effects of medication on patient's physical health regularly and in line with National Institute for Clinical Excellence guidance, there were no patients who were prescribed high dose antipsychotics.

Track record on safety

Between 1 October 2017 and 30 September 2018 there were no serious incidents reported by this service.

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 none 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.

Reporting incidents and learning from when things go wrong

The ward had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff we spoke to knew how to report incidents using the electronic system on the computer desktop and explained how they would complete an incident form.

Staff reported all incidents that they should report. Staff gave examples of the types of incidents that they would report such as a falls or manual handling failures.

Staff were able to explain the duty of candour and had good relationships with patient's family and carers, providing honest information if things went wrong.

Staff received information from investigation of incidents, both internal and external to the service. Staff told us that lessons learnt were fed back through team meetings, staff huddles and emails. The ward manager was the lead for the Learning Disabilities Mortality Review and shared lessons learnt from that forum. However, staff could not feedback any specific examples of lessons learnt shared through the Learning Disabilities Mortality Review.

The trust had a policy on debriefing which was accessible to all staff. Staff told us that they would receive a debrief after an incident. The ward manager provided an example of a patient death two years ago where the team were provided with a debrief and had a team day and peer supervision to support one another.

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 five 'prevention of future death' reports sent to the trust, none of which related to this service.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of the patient in a timely manner at admission. We looked in detail at three patients care records and found robust and good quality, detailed assessments of patient needs, which were completed on each admission to respite, every five weeks.

Staff assessed patient's physical health needs on admission. Due to the complex nature of the patient group, there were a number of physical health elements to each patient's care that required ongoing monitoring, such as personal hygiene, skin integrity and epilepsy. These were clearly detailed in patient care plans, with the interventions needed to support those needs. Staff also undertook basic physical health observations such as blood pressure, temperatures and weight. Annual physical health assessments were completed by the consultant or junior doctor.

Staff developed care plans that met the needs identified during assessment. We found that care plans were very detailed, personalised, holistic and met the needs of the individual patient. Each need that was identified had its own care plan on the electronic system, with patients having as many as 12 separate care plans. For example, mobility, communication, social, skin integrity, safe environment and nutrition and hydration. Care plans included assessments and monitoring from allied health professionals such as speech and language and physiotherapy.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

Staff provided a range of care and treatment interventions suitable for the patient group. Staff followed National Institute of Clinical Excellence guidelines. National Institute Clinical Excellence guidelines and other guidance were documented as rationale for carrying out specific interventions relating to individual care plans. For example, the Backcare guide to patient handling (2005) was used as rationale for following certain protocol in a care plan around mobility.

Staff at the service provided patients with a number of alternative therapies such as therapeutic massages, manicures and pedicures, gardening and music sessions. Patients were supported to leave the service as much as possible to access community services such as day services and the local coffee shop. Staff worked on a need's basis for each patient and worked within their abilities. Art therapy had been reintroduced and both staff and patients worked together to create a silk and salt painting which was displayed in the service.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Patients had access to physiotherapists and speech and language therapists located on site, to support mobility and dysphagia.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. There were a number of patients accessing the service that had a percutaneous endoscopic gastronomy (PEG) in place. Staff were trained in meeting these patients' nutritional needs. Staff monitored food and fluid intake and we observed food and hydration charts on patient's electronic care records.

Staff supported patients to live healthier lives. Staff supported patients to lead healthy lives through health eating advice and promoting exercise. We observed staff taking patients off the ward to take part in a walking group. Those that had restricted mobility were supported to take part in the group by using their wheelchair. Staff told us that patients were supported to access national screening whilst in respite.

Staff used recognised rating scales to assess and record severity and outcomes. Staff used The Health Equalities Framework (HEF) to monitor patient outcomes and this was evidenced in patient care plans. The physiotherapy team used the Oxford 24/7 postural management assessment to monitor patient outcomes.

Staff used technology to support patients effectively, allowing for the sharing of patient information across the service.

This service did not participate in any clinical audits as part of their clinical audit programme 2017 - 2018. However, the team discussed clinical safety through a number of forums. Staff carried out a local audit of care planning and achieved a 100% target. The service had also taken part in a trust wide audit of health and social care records, achieving green in all areas.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of disciplines including nurses, doctors, occupational therapists, speech and language therapists and physiotherapists to meet the needs of the patient group.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff were provided with specialist role training such as autism, epilepsy, communication, end of life care and could request appropriate training if needed. The physiotherapy team had provided nursing staff with training in postural management and had put a postural program in place in a pictorial format for nursing staff to follow to support patients posture. Speech and language therapists provided nursing staff with training on dysphagia that was bespoke around individual need.

All staff received an induction when joining the trust and local teams provided an orientation to ensure they were aware of their policies and protocols. Managers provided staff with an induction that was based primarily on learning disabilities and new starters were allocated a buddy to observe and shadow. All new healthcare assistants were also supported to complete their care certificate.

Managers told us that staff received both clinical and managerial supervision and that there were peer support meetings regularly taking place to discuss any patient issues. Whilst most staff told us that they received one to one supervision, this was not evidenced and documented in line with the trusts supervision policy. A member of staff told us that supervision was not documented properly. It was explained that supervision would take place and that the supervisee would update an excel spreadsheet with the date of their supervision. During our inspection, we saw this

spreadsheet and there was a large amount of data that had not been completed to evidence that supervision had taken place across the staffing team.

The trust's target rate for appraisal compliance was 90%. 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 88%. At 30 November 2018, the overall appraisal rate was 77%.

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 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
Oak House	13	10	77%	88%
Core service total	13	10	77%	88%
Trust wide	**4490**	**3615**	**81%**	**88%**

Staff received annual appraisals of their performance and staff told us that they had received their appraisal in the last 12 months and found them to be useful. Managers dealt with poor staff performance promptly and effectively and the trust had a human resources department to support managers with this.

The trust was not able to provide any data for the clinical supervision of staff.

Managers ensured that staff had access to regular team meetings. The minutes of these meetings were emailed to all staff to ensure all staff were up to date with information such as lessons learnt, incidents and complaints.

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. Staff were supported and provided with time to access relevant training.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

The service held a multidisciplinary team meeting a on a monthly basis to ensure patient safety and develop patient care plans. These meetings included a range of professionals such as nurses, consultants, speech and language therapists and physiotherapists. The minutes of these meetings were sent and distributed to staff who could not attend. Essential information was also recorded in a communication book which staff checked when coming on shift.

Staff shared relevant information about patients at effective handover meetings within the team. There were three handovers a day, between each shift changeover. We observed a handover where information about each patient's last 24 hours was handed over regarding physical health, activities and risk, using information recorded on the patients electronic file. Staff used 'patient at a glance boards' to record essential information, such as physical health checks, which were accessible immediately to identify when tasks needed to be carried out.

Staff had strong and effective relationships with each other and other relevant teams, such as the community team located on site. The service had effective working relationships with Shrewsbury Hospital, particularly the neurology department, local authorities and GPs.

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 and discharged these well.

As of 30 November 2018, 83% of the workforce in this service had received training in the Mental Health Act. The trust stated that the training was mandatory for all services for inpatient and all community staff and renewed ever three years.

Whilst staff received Mental Health Act training, the service did not admit patients who were detained under the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff demonstrated a good understanding of mental capacity. Overarching assessments of mental capacity care decisions were recorded, including accessing respite care, leading to admission of the unit.

As of 30 November 2018, 100% of the workforce in this service had received training in the Mental Capacity Act Level 2. The trust stated that this training was mandatory for all services for inpatient and all community staff and renewed every three years.

The trust told us that six standard Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 October 2017 and 30 September 2018.

The greatest number of Deprivation of Liberty Safeguards (DoLS) applications were made in October 2017 and June 2018 with two.

CQC received 129 direct notifications from the trust between 1 October 2017 and 30 September 2018. This is more than double the number the trust told us about in the PIR. We are not able to break the CQC data down by core service.

	Number of 'Standard' DoLS applications made by month (Trust data)												
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	**Total**
Standard applications made	2	0	0	0	0	0	1	1	2	0	0	0	**6**
Standard applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Of the three patient records that we looked at, we saw that staff assessed mental capacity to agree admission for every admission to respite. We also saw that best interest decisions were in place.

The trust had a policy on the Mental Capacity Act, including the Deprivation of Liberty Safeguards (DoLS). Staff told us that they were aware of the policy and knew how to access it.

Staff took all the practical steps to enable patients to make their own decisions. Staff supported patients through different methods of communication, such as prompt cards or pointing, to support patients to make everyday choices.

When patients lacked capacity, staff made decisions in their best interest, recognising the importance of the person's wishes, feelings, culture and history. Due to the patient group, the majority of patients lacked capacity. Staff screened for mental capacity at every admission to respite care. We saw that best interest decisions were place in the three patient records that we looked at.

Staff made Deprivation of Liberty Safeguards applications when required and monitored the progress of applications to supervisory bodies. Managers informed us that they had seven successful applications with one local authority and were awaiting to hear about 11 other applications from another local authority, who were experiencing a backlog. The team had good oversight on their applications.

The service had arrangements to monitor adherence to the Mental Capacity Act and audited the application of the Mental Capacity Act.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff were observed in the ward displaying excellent interpersonal skills, using prompt cards and signs to communicate with patients and responding to patient cues. Staff demonstrated respect by involving patients in decisions and giving them a choice in what they wanted to do and how they wanted to do it.

Staff supported patients to manage their care and treatment. Staff we interviewed told us that they were very proud of the care that was provided and how patients were valued and at the centre of their care.

Staff supported patients to access other services such as hospital and dental appointments whilst in respite. Patients were empowered to do as many activities as they could, as independently as they could, for example laundry, cleaning and making drinks.

The carers that we spoke to said that staff treated their relatives well and behaved appropriately towards them.

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

Staff we spoke to felt able to escalate any concerns that they may have about discriminatory or abusive behaviour or attitudes towards patients.

Staff maintained the confidentiality of information about patients. In the nursing office, no personal information was visible from outside the office, using a blind to hide identifiable information.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at Oak House scored lower than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Oak House	Wards for people with learning disabilities or autism	87.1%
Trust overall		**96.9%**
England average (mental health and learning disabilities)		**91.0%**

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment. Staff listened to and observed patient's wishes and needs and this was reflected in patients care plans. Staff also spoke with carers to discuss patient needs.

We were unable to speak to any patients during our inspection, as the patients that were on the ward at the time were unable to communicate effectively with us.

The admission process was used by staff to inform and orient patients around the service.

Staff found appropriate ways to communicate with patients. This included hand gestures and prompt cards, so that they understood their care and treatment.

Patients were involved, when appropriate, in decisions about the service. For example, about decoration around the ward.

Staff enabled patients to give feedback on the service they were receiving, in a way that was suitable for the individuals' needs. Staff used suitable communication methods to obtain feedback.

Patients could access advocacy if required.

Involvement of families and carers

Staff informed and involved carers appropriately and provided them with support when needed. There was evidence of carer involvement in all patient care plans that we looked at, with a section documenting the carers understanding of the intervention being used. We spoke to four carers who all stated that they could not fault the service and the level of support that was provided to their relative. All carers spoken to felt that their relatives' needs were understood and met, and that staff had a real understanding of their relative's likes and dislikes. Staff had built a great rapport with patients and carers spoken to knew that their relative was safe and happy whilst accessing respite. The service had a carers lead that carers could contact, and their information was displayed in the reception area.

Carers told us that the service was very flexible and often went above and beyond for their relative. One carer gave an example of the service taking their relative to a funeral on a non-respite week and providing respite days that were flexible to meet the needs of their relative.

Staff enabled families and carers to give feedback on the service they received.

Staff provided carers with information about how to access a carers assessment. The carer welcome pack provided information on this and the other services available to carers.

Is the service responsive?

Access and discharge

Accepted and changed.

Staff planned and managed service users' admissions and discharges from the respite service well. Staff liaised well with carers to plan their respite dates and to ensure the relevant clinical information was handed over before and after each respite stay.

Bed management

The trust provided information regarding average bed occupancies for Oak House between 1 October 2017 and 30 September 2018.
Beds were allocated to 18 patients throughout the year. The service worked on a rotating basis whereby the same cohort of four to five patients were admitted every five weeks for planned

respite. This allowed the service to have oversight of when beds would be occupied throughout the year.

Bed occupancy was routinely low as new referrals were rare and only five of the 10 beds available were used at any one time. Therefore, occupancy was lower than the trusts 85% benchmark.

Ward name	Average bed occupancy range (1 October 2017 – 30 September 2018) (current inspection)
Oak House	35.36% – 46.45%

When patients accessed respite care, they returned to the same room on every admission to ensure familiarity and continuity for patients. When patients were discharged and readmitted, this occurred at an appropriate time of day.

The trust provided information for average length of stay for the period 1 October 2017 to 30 September 2018.

Ward name	Average length of stay range (1 October 2017 – 30 September 2018) (current inspection)
Oak House	4.05 – 7.93

This service reported no out of area placements between 1 October 2017 and 30 September 2018.

This service reported 158 readmissions within 28 days between 1 October 2017 and 30 September 2018. All of the readmissions were to the same ward as discharge. The average number of days between discharge and readmission was 21 days. There were two instances whereby patients were readmitted on the same day as being discharged and there were none where patients were readmitted the day after 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
Oak House	158	158	100%	0 - 28	21
Total	**158**	**158**	**100%**	**0 - 28**	**21**

Discharge and transfers of care

Between 1 October 2017 and 30 September 2018 there were 219 discharges within this service. This amounts to 6% of the total discharges from the trust overall (3684). None of the discharges from this core service were delayed.

Ward name	Number of discharges	Number of delayed discharges	% Delayed
Oak House	219	0	0%
Total	**219**	**0**	**0%**

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

The facilities at Oak House promoted comfort, dignity and privacy for all patients. Patients had their own bedrooms and a photograph was placed on the front door to identify who the bedroom belonged to and to help orient patients.

Patients were able to personalise their bedroom if they had the capacity to do so.

Bedrooms had a bed, wardrobe and sink and secure storage for patients to store their personal belongings.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. The facilities were comfortable and pleasant and supported the privacy and dignity of patients. The service had sufficient rooms and space to provide a therapeutic environment for patients. There was an activity room with sports equipment, along with a dining room and television lounge. There was an activity board displayed in the activity room which detailed the weeks activities in a pictorial form.

Each ward had a fully equipped clinic room. Due to the size of the room and the needs of the patient group, physical examinations were undertaken in patient bedrooms.

There was a quiet room and place for patients to receive visitors if they wished to.

Patients were able to make private telephone calls, if they had capacity to do so.

Patients had access to a secure outside space with a garden to the rear of the building for fresh air and recreational activities. During the summer months, patients took part in gardening activities.

Patients were promoted to make their own drinks and do their own laundry, if they had the capacity to do so.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at Oak House scored higher than similar trusts.

Site name	**Core service(s) provided**	**Ward food**
Oak House	Wards for people with learning disabilities or autism	95.6%
Trust overall		**94.9%**
England average (mental health and learning disabilities)		**92.2%**

Patients' engagement with the wider community

Staff supported patients to engage with the wider community. Where appropriate, staff supported patients whilst on respite to access the day services that they usually attend.

Patients were supported to maintain relationships with their family and carers whilst accessing respite.

Staff supported patients to develop and maintain relationships with those that mattered to them, both within the service and the wider community. Carers we spoke to told us that they could contact their relative whilst on respite, should they wish to.

Meeting the needs of all people who use the service

The ward met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service was well equipped to meet the needs of patients with disabled access throughout the ward with wide door frames and specially adapted beds. Bathing and toilet facilities were provided for those that used a wheelchair or those with restricted mobility. There were plenty of hoists available and patient beds were adjustable. Whilst there were signs on the doors to help orientate

patients around the ward, they were not very clear or large. A sign on the toilet in the male corridor, had both a male and female picture.

Information was provided and communicated to patients in an accessible way, through hand gestures, prompts and picture cards. Easy Read Care Plans were available for service users who can access this form of information. The service had access to Makaton, a language programme that uses signs and symbols to help people communicate. Information was also available in nonstandard formats from the community team located on site. All patients had hospital passports to support access to the acute hospital.

Information could be made accessible in languages spoken by patients and interpreters were available on a need's basis.

Patients were offered a choice of food to meet their dietary requirements at mealtimes, and these were documented in care plans.

Staff supported patients to access spiritual support, should they request to.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018) the location scored higher than similar trusts for the environment supporting those with disabilities.

Site name	Core service(s) provided	Dementia friendly	Disability
Oak House	Wards for people with learning disabilities or autism	-	98.3%
Trust overall		**98.1%**	**98.1%**
England average (Mental health and learning disabilities)		**88.3%**	**87.7%**

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, which were shared with all staff

This service received no complaints between 1 October 2017 and 30 September 2018.

Welcome packs provided to patients and carers contained information on how to make a complaint. Carers told us that they knew the process to make a complaint, should they need to.

Staff told us that they would know how to deal with a complaint, should they receive one but told us that they rarely received any complaints. When they did receive a complaint, staff received the feedback on the outcome of investigation of complaints and acted on the findings.

This service received seven compliments from 1 April 2018 to 31 March 2019.

Is the service well-led?

Leadership

Leaders had a very good understanding of the service and patient group they managed. They could explain clearly how the teams were working to provide high quality care. They demonstrated passion and commitment in their role, towards staff, patients and their carers.

Leaders we interviewed communicated effectively with their staff and demonstrated good leadership skills.

Leaders were visible in the service and approachable for patients, staff and carers. Carers reported that they were able to call the service whenever they needed to speak to a manager or any other staff member. Staff told us that the leadership was excellent, and they felt valued and

supported by managers, particularly during a time of uncertainty for the future of the service. Staff told us that senior managers visited the service regularly and knew the staffing team well.

Leadership development opportunities were available, including opportunities for staff below managerial level. The ward manager told us that they were undertaking a degree in epilepsy that was supported by the trust. Staff were also encouraged to build up and develop their existing skillset.

Vision and strategy

Staff we spoke with knew and understood the trust's vision and values and how they applied to their work within the service and placed the patient at the centre of all care.

The trusts senior leadership team had successfully communicated the providers vision and values to the frontline staff.

Staff had the opportunity to contribute to discussions about the strategy for their service. However, as the service was going through a review, staff felt that there was little communication from the trust about the future of the service and the provision for patients.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff told us that they felt valued, respected and supported by their line managers and senior managers, particularly through a time of uncertainty with the future of the service.

Staff felt proud about working in their team within the trust and were committed to their role, the team and the patients.

Staff felt able to raise concerns without fear of retribution. Staff told us that they felt able to raise any concerns with their line manager and could escalate anything higher, should they need to.

Staff knew how to use the whistleblowing process, but none of the staff we spoke to were able to identify or explain the role of the Freedom to Speak Up Guardian.

Managers dealt with poor staff performance when needed, through supervision and appraisals, and were supported by the human resources team.

Teams worked well together and where there were difficulties, managers dealt with them appropriately. During our inspection, we observed teamwork and positivity.

Staff reported that the trust promoted equality and diversity in its day to day worked in providing opportunities for career progression.

Staff appraisals included conversations about career development and how it could be supported.

The service's sickness and absence rates were roughly 3% higher than the trust. Managers explained that there was a member of staff on long term sickness.

Staff had access to support their own physical and emotional wellbeing through occupational health and peer support. Staff told us that the team had been a great source of support for one another in regard to the uncertain feelings of the service review. Staff told us that due to the service review, there was a lot of peer support and support from managers through informal forums.

The trust recognised staff success within the service and the service had won a number of awards which were proudly displayed. The ward manager had recently won a certificate for appreciation for demonstrating dedication in motivating the team.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

There were governance systems in place to ensure the safe and effective running of the service.

There were lead roles in place for specific areas such as carer engagement, safeguarding and infection control and the ward manager had oversight of these roles.

The trust incident reporting tool was easy for staff to use and they knew what and how to report any incidents. Managers had clear oversight of all incidents that were reported, and any key themes of issues were discussed with the wider team through team meetings and staff huddles.

Managers had oversight of supervision, appraisals and mandatory training.

There was a clear framework of what must be discussed at a ward and team 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.

Staff undertook and participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. There were good working relationships with the community team.

Management of risk, issues and performance

The ward had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register at ward level. Staff could escalate concerns to managers when required.

The concerns of staff matched those on the risk register.

The service had plans for emergencies including adverse weather and fire.

Where cost improvements were taking place, they did not compromise patient care. However, with the service review and block on recruitment, the service was closing every five weekends due to staffing levels. Managers informed us that this had no impact on patient care.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The systems in place were electronic and secure and staff were trained in how to use them. This included the patient information system which staff told us was accessible and easy to use. Where paper copies were used, these were stored in locked cupboards and were updated regularly. The service used systems to collect data from the service that were not over burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records. Staff were trained in information governance and demonstrated clear understanding.

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.

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

Staff made notifications to external bodies as needed including the local authority and the CQC.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Staff, patients and carers had up to date information about the work of the trust and the services they used. This was communicated via newsletters, the intranet and general meetings.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from patients, carers and staff used it to make improvements.

Patients and carers were involved in decision-making about smaller changes to the service. However, carers felt concerned about the uncertainty of the future of the service, with little communication from the trust.

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

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Staff were given time and support to consider opportunities for improvements and innovation. There were leads in place for clinical practice such as infection control, carers etc. who implemented best practice into these areas.

Staff used quality improvement methods and knew how to apply them. The service had taken part in a number of audits around the quality of care planning to improve their quality.

Staff participated in national audits relevant to the service and learned from them.

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)
Hall Court	CRHT T&W	Not provided	Mixed
St George's Hospital	CRHT West South Staffs	Not provided	Mixed
St George's Hospital	Health Based Place of Safety (section 136) Stafford	Not provided	Mixed
St Michael's Hospital	CRHT East South Staffs	Not provided	Mixed
The Redwoods Centre	CRHT Shropshire.	Not provided	Mixed
The Redwoods Centre	Health Based Place of Safety (section 136) Shrewsbury	Not provided	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.

There were two Access teams, four Crisis Resolution and Home Treatment teams, two health based places of safety and four Mental Health Liaison Teams operating across Midlands Partnership NHS Foundation Trust. We inspected all of these services. They were based at St Georges and County Hospitals in Stafford, The Redwoods Centre and the Royal Shrewsbury Hospital in Shrewsbury, Hall Court and the Princess Royal Hospital in Telford, St Michaels Hospital in Lichfield and Queens Hospital in Burton-upon-Trent.

The teams operated 24 hours seven days a week. The main function of the Access teams was to provide a single point of contact for all referrals to the trust's adult mental health services. The team consisted of qualified health and social care staff who provided assessment, and assistance to individuals to access the right services. Patients could self-refer to the Access teams as well as be referred by professionals, such as GPs, health visitors, and the police.

The Crisis and Resolution Home Treatment teams supported patients whose mental health was deteriorating and required urgent intervention. These teams also supported patients to avoid admission into hospital, through the provision of short periods of intensive home support. The team was made up of doctors, nurses, social workers, Occupational Therapists and support workers who were available to support patients, carers and their families. The team was made up of doctors, nurses, social workers and support workers who were available to support patients, carers and their families. The teams 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 Crisis and Resolution Home Treatment teams worked closely with the Access teams to provide support to people in crisis.

The health based places of safety comprised a three-bed unit at St George's Stafford and a one-bed facility based at the Redwoods Centre in Shrewsbury. These places of safety accommodated patients who had been brought in by the police and detained 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.

The mental health liaison teams assessed patients who presented with mental health problems at the acute hospital emergency departments in Shrewsbury, Stafford, Telford and Burton-upon-Trent. Patients assessed in these hospitals were referred to the Access, Crisis and Resolution

Home Treatment teams and if appropriate the integrated care pathways offered by the trust. The teams consisted of mental health nurses and psychiatrists.

The Care Quality Commission (CQC) last inspected the service in 2016 as part of a comprehensive inspection of South Staffordshire and Shropshire Healthcare NHS Foundation 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 Requires Improvement.

Is this service safe?

Safe and clean environment

All premises we inspected, where patients had access including common areas and 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 escorted patients from waiting areas to assessment rooms and did not leave them unaccompanied.

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 and regularly serviced.

Heath-based place of safety

The suites used for patients detained under section 136 of the Mental Health Act contained equipment and furniture that met with current safety standards. The suite in Stafford contained three rooms and a secure outside garden area. This area did have potential ligature points. However, we were told that all patients would always be observed when in this area. No other ligature points were observed within either of the suites. Staff had personal alarms for use and other staff from adjacent wards were available to attend in an emergency. Both places of safety had equipment for monitoring and assessing patients' physical health needs, including resuscitation equipment. Both units were visibly clean, well maintained and safe.

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 and covered recent staff maternity leave safely although staff told us that staff vacancies had caused extra work for them. The teams employed regular bank staff from their own pool of bank staff familiar with working in crisis and home treatment services. All bank staff were trained in the trust's recording and care planning systems. The teams held a team caseload and patients had a team of three professionals named as 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 four home treatment teams held caseloads of between nine and 27 each. The mental health liaison teams based at the emergency departments in the local hospitals did not hold a caseload.

Health-based place of safety

The trust did not permanently allocate staff to their two health-based places of safety due to their sporadic and unpredictable use. Staff from nearby inpatient wards were used when patients were admitted to the suites. The staffing of the suites in each case was based on an individual risk assessment carried out by the senior nurse on duty. The trust did not open the suites unless there was a minimum of two staff available. Occasional agency staff were employed, and these staff were familiar with the work of the suites. Incident reports for the period 1 April 2018 to 31 March

2019 showed that the trust closed their health-based places of safety for 106 shifts due to not having enough staff available. However, there were no incidents reported for the same period of the suites being left with fewer than two staff or falling below the required safe staffing levels. This meant that in all cases when the suites were open staff were available to assist in an emergency to keep people safe from harm and to provide the right care and treatment. On nine occasions the police were required to guarantee safer staffing and on three occasions safe staffing levels were ensured by the site manager remaining on site.

Nursing staff

As of 30 September 2018, this core service had reported a vacancy rate for all staff of less than 1%, -1% for registered nurses and 5% (over establishment) for nursing assistants.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Hall Court	CRHT T&W	1.7	18.0	9%	1.4	8.0	17%	2.0	30.0	7%
Redwoods Centre	CRHT Shropshire	1.2	18.9	6%	-0.2	9.1	-2%	2.0	31.0	6%
St Michaels Hospital	CRHT East South Staffs	-1.8	15.0	-12%	0.0	11.0	0%	-1.8	29.0	-6%
St Georges Hospital	CRHT West South Staffs	-1.8	16.0	-11%	0.7	10.0	7%	-2.1	29.0	-7%
	Core service total	**-0.8**	**67.9**	**-1%**	**1.9**	**38.1**	**5%**	**0.1**	**119.0**	**<1%**
	Trust total	**140.5**	**1969.7**	**7%**	**146.8**	**1424.0**	**10%**	**536.1**	**5645.8**	**9%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 30 September 2018, of the 136881 total working hours available, 3% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

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

In the same period, agency staff did not cover any available hours for qualified nurses and less than 1% of 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**	**%**
CRHT East South Staffs	31320	393	1%	0	0%	56	0%
CRHT T&W	35235	2600	7%	0	0%	19	0%
CRHT West South Staffs	33278	863	3%	0	0%	149	0%
CRHT Shropshire.	37049	0	0%	0	0%	0	0%
Core service total	**136881**	**3857**	**3%**	**0**	**0%**	**224**	**<1%**
Trust Total	**3781640**	**96462**	**3%**	**38953**	**1%**	**25030**	**1%**

Between 1 October 2017 and 30 September 2018, of the 69433 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

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

In the same period, agency staff did not cover any available hours for qualified nurses and less than 1% of 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	%
CRHT East South Staffs	17618	296	2%	0	0%	33	0%
CRHT T&W	14035	137	1%	0	0%	11	0%
CRHT West South Staffs	20554	600	3%	0	0%	67	0%
CRHT Shropshire.	17226	0	0%	0	0%	0	0%
Core service total	**69433**	**1032**	**1%**	**0**	**0%**	**110**	**<1%**
Trust Total	**1847533**	**220632**	**12%**	**78422**	**4%**	**38181**	**2%**

This core service had nine (8%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Hall Court	CRHT T&W	27.9	3.0	11%
St Georges Hospital	CRHT West South Staffs	31.1	3.0	10%
Redwoods Centre	CRHT Shropshire	29.0	2.0	7%
St Michaels Hospital	CRHT East South Staffs	30.8	1.0	3%
Core service total		**118.9**	**9.0**	**8%**
Trust Total		**5109.7**	**679.3**	**14%**

The sickness rate for this core service was 4.9% between 1 October 2017 and 30 September 2018. The most recent month's data (30 September 2018) showed a sickness rate of 4.6%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % staff sickness (over the past year)
St Michaels Hospital	CRHT East South Staffs	6.3%	6.7%
Hall Court	CRHT T&W	4.4%	4.5%
Redwoods Centre	CRHT Shropshire	2.5%	4.3%
St Georges Hospital	CRHT West South Staffs	5.2%	4.2%
Core service total		**4.6%**	**4.9%**
Trust Total		**4.7%**	**5.2%**

Medical staff

Between 1 October 2017 and 30 September 2018, of the (7,830) total working hours available, none were filled by bank or agency staff to cover sickness, absence or vacancy for medical locums.

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	%
CRHT T&W	1958	0	0%	0	0%	0	0%
CRHT West South Staffs	1958	0	0%	0	0%	0	0%
CRHT East South Staffs	1958	0	0%	0	0%	0	0%
CRHT Shropshire	1958	0	0%	0	0%	0	0%
Core service total	**7830**	**0**	**0%**	**0**	**0%**	**0**	**0%**
Trust Total	**396315**	**2237**	**1%**	**38147**	**10%**	**1680**	**0%**

Mandatory training

The compliance for mandatory and statutory training courses at 30 November 2018 was 84%. Of the training courses listed, 11 failed to achieve the trust target and of those, four failed to score above 75%. However, this had no patient impact as managers had ensured compliance soon after, and at the time of inspection the overall score for mandatory training was 90.6%

The trust set a target of 90% for completion of mandatory and statutory training. The trust reports training on a month by month rolling basis.

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
Manual Handling - Object	5	5	100%	✓
Safeguarding Adults (Level 1)	116	116	100%	✓
Safeguarding Children (Level 2)	116	116	100%	✓
Equality and Diversity	116	115	99%	✓
Mental Capacity Act Level 2	113	112	99%	✓
Promoting Safer and Therapeutic Services	113	111	98%	✓
Local Induction	116	111	96%	✓
Prevent Awareness	116	103	89%	✖
Safeguarding Children (Level 3)	75	63	84%	✖
Fire Safety - 1 Year	116	93	80%	✖
Clinical Risk Assessment	79	63	80%	✖
Infection Prevention (Level 1)	112	89	79%	✖
Conflict Resolution	4	3	75%	✖
Adult Basic Life Support	110	82	75%	✖
Information Governance	116	85	73%	✖
Mental Health Act	80	55	69%	✖
Medicine management training	70	46	66%	✖
Manual Handling - People	111	48	43%	✖
Total	**1684**	**1416**	**84%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 22 home treatment team patient care records across different sites and found risk assessments and risk management plans were completed satisfactorily. All patients had an electronic health record and the risk management plans were contained within these records. A physical health risks assessment was missing in almost all the records we reviewed. This meant that staff working with patients could not be alerted to such risks from reading the patient notes alone. Staff took a standardised approach to risk by using the template within the electronic patient record. Staff used this tool to assess the severity of patient risk and take the appropriate action. Staff at the access and home treatment teams regularly monitored 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 patient risk

Community staff adhered to a lone working policy and any concerns identified prior to a visit were planned for. All staff had an expected time of arrival back at the office and there was a safe code word used to alert base staff to problems when staff were out visiting patients. Staff were in regular contact with patients and responded promptly to a deterioration in a patient's health. Staff followed up on patients if they missed appointments to ensure their safety. Staff also gave carers their contact numbers and encouraged to them to contact if patients were having problems or were at risk.

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 at risk 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 at risk, 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 32 safeguarding referrals between 1 October 2017 and 30 September 2018, of which 15 concerned adults and 17 children.

Number of referrals		
Adults	**Children**	**Total referrals**
15	17	32

The number of adult safeguarding referrals made per month ranged from none to four and the number of child safeguarding referrals made per month also ranged from none to four.

Staff we spoke to understood the trust's safeguarding policies and procedures and those of the local authority. All staff knew how to make safeguarding referrals to their local authority and how they should document their concerns appropriately. We saw evidence that staff had made safeguarding referrals to the local authority and raised their concerns with their senior managers. Staff also knew who the trust head of strategic safeguarding was and how to contact them for

advice. The trust had submitted details of two serious case reviews commenced or published in the last 12 months (1 October 2017 to 30 September 2018). However, none related to this service.

Staff access to essential information

Staff kept records of patients' care and treatment using an electronic patient record. Staff did not keep paper records with clinical information on them. Staff told us they had been trained in using these digital records which allowed them to monitor patient care across the services. The records were available to all staff providing care and were clear, up-to-date and contained relevant current and historical clinical information. Staff also made innovative use of common software packages to ensure all information was in one place. This included up to date information on correct care pathways, available doctors and templates for referral.

Health-based place of safety

An initial paper referral form was completed by the police and handed to trust staff when admitting patients to the places of safety under section 136 of the Mental Health Act. Staff also accessed the electronic health care records for existing information on patients admitted. Information from the paper form was uploaded to the electronic patient record. This information included a risk assessment, substance misuse and physical health early warning information. Staff 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

Staff worked mostly with patients who held and managed their own medication. However, staff did supervise consumption or hold medication for patients, with their consent, in the small minority of cases where there was an overdose risk. In these cases, staff carried medications in sealed pouches in briefcases in accordance with the trust medicines management policy. In all cases, except for services based in Shrewsbury, a pharmacist was available to provide advice, and audits were carried out every month in line with guidance from the National Institute for Health and Care Excellence.

Health-based place of safety

Medicines were not stored within the places of safety. Doctors could prescribe medicines and staff could access medicines when required. This included symptomatic medications for the management of withdrawal from illicit drugs.

Track record on safety

Between 1 October 2017 and 30 September 2018 there were 13 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 12.

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 13 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.

	Number of incidents reported		
Type of incident reported (SIRI)	Apparent/actual/suspected self-inflicted harm	Apparent/actual/suspected homicide	**Total**
CRHT Shropshire	5	0	**5**
CRHT South Staffordshire West	3	0	**3**
CRHT South Staffordshire East	1	1	**2**

	Number of incidents reported		
Type of incident reported (SIRI)	Apparent/actual/suspected self-inflicted harm	Apparent/actual/suspected homicide	**Total**
CRHT Telford and Wrekin	2	0	**2**
Redwoods 136 Suite	1	0	**1**
Total	**12**	**1**	**13**

Reporting incidents and learning from when things go wrong

Staff we spoke to knew how to report incidents using the trust's systems and procedures. All staff discussed incidents within their teams and with their managers in supervision. Staff told us that the trust also shared the final reports and outcomes of incident investigations with them and the feedback from these was discussed at team meeting to identify points of learning. Staff told us that they developed their fast track back initiative through this learning process after an incident. The crisis and home treatment team in Stafford offered a dedicated telephone number to patients for use within seven days of discharge. This facility allowed patients to quickly reconnect with their key worker team if, in hind sight, they did not feel safe for discharge. Patients did not use this service often, but staff told us that patients said it provided them with reassurance. Staff understood their duty of candour and knew to be open with patients if mistakes were made. There was a system of staff debrief in place across all services and included high level support to staff if required.

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 five 'prevention of future death' reports sent to the trust, none of which related to this service.

Health-based place of safety

Staff knew when to report incidents and had opportunity to discuss incident with senior staff at ward team meetings. Staff also discussed incidents within the section 136 heads of service meeting which included the police and the local authority. 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 22 patients' care records and found good assessments of patient's mental health and that these were completed promptly. We found that care records contained up to date personalised and holistic information and care plans met the needs identified during assessment. We also found evidence of patients collaborating with staff in developing their care plans. Assessments were completed on the electronic patient record and included an initial assessment and care plan. Whilst staff told us they were aware of patients' physical health needs and responded to their health issues appropriately, we could not find evidence of this in care plans. We were told there were members of staff nominated to lead on physical health. However, this was for maintenance of equipment rather than for developing physical health initiatives, to audit physical health interventions or to further staffs understanding of the importance of physical health assessment or care planning. Staff did undertake basic physical health checks for some patients. However, this could be as low as 40% of the caseload in some services. Interventions included blood tests when commencing new medicines and basic physical health observations such as blood pressure, temperatures and weight.

Health-based place of safety.

Staff recorded patients' mental health assessments on the electronic patient record. This was available to other professional if the patients accessed other services within the trust. Clinical information recorded on paper files was kept securely in locked filing cabinets until it was uploaded to the electronic patient record.

Best practice in treatment and care

We found evidence that staff undertook and participated in clinical audits. Staff regularly audited medication and care planning as well as their response times. Staff followed National Institute for Health and Care Excellence (NICE) guidance by ensuring systems were in place to offer a care plan to users experiencing a crisis or to those at risk of one. Staff also ensured the continued improvement of care for people using mental health services by treating patients in a friendly, professional manner, and by keeping waiting times to a minimum. None of the crisis and health based places of safety teams had direct access to psychological services. However, this was available by referral of patients to the trust's remodeled community pathways and did not create a delay or have an impact on patient care. All services offered referral to support services for housing and benefits, substance misuse, domestic violence and other agencies dealing with wide range of social health and care issues. All the teams had protocols for attending to the basic physical healthcare needs of their patients using validated tools and provided advice on healthier living.

Health-based place of safety

Staff told us that they had reassessed their clinical practice when the Policing and Crime Act 2017 made changes to the length of time someone could be detained under section 136 of the Mental Health Act from 72 hours to 24 hours. Records showed that assessment of patients started within three hours, unless there were clinical grounds for delay. Staff completed regular audits and checks of the resuscitation equipment.

Skilled staff to deliver care

All the teams had access to mental health disciplines that included nurses, doctors, and social workers. However, psychologists were only available through referral to the community mental health pathways in each area. There were regular pathways referral meetings to consider where patients were best placed and to prevent multiple assessments taking place. Staff undertook joint assessments to ensure patients had a seamless treatment journey. Staff we spoke to in all services were experienced and qualified for their clinical roles and some were trained to provide psychosocial interventions such as low level cognitive behavioural and solution focused therapy. These interventions met with guidance issued by the National Institute for Health Care and Excellence.

All staff received an induction when joining the trust and local teams provided a local orientation to ensure they were aware of their policies and protocols. Managers worked with staff to identify their learning needs and to provided them with opportunities to develop their skills and knowledge. At the time of inspection, we were told that staff were undertaking post graduate training to enhance their existing skills as well as partaking in other specialised training. Managers dealt with poor staff performance promptly and used measurable objectives to help staff return to their original competence. Senior staff were aware that recent organisational change might have affected performance and morale. However, it was reported, and we observed, that the recent organisational changes had not had any impact on patient care.

Supervision of staff took place regularly in all teams every four to six weeks in line with trust policy. Staff told us they felt well supported and had the opportunity to receive group supervision if they required further support from psychologist colleagues. Clinical leads also organised away days for staff to consider clinical issues and team cohesion. Staff received annual appraisal of their clinical skills and abilities for working within all the crisis and health-based places of safety teams. This included 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.

Health-based place of safety

Staff who worked within the health-based place of safety suites from adjacent wards were experienced and had the right skills and knowledge to meet the needs of the patient group staying at the places of safety and were familiar with the how to respond to issues such as substance misuse and self-harm. Staff were supported with the provision of information and knowledge specifically about the place of safety and received supervision from senior clinical staff with responsibility and oversight of the suites.

The trust's target rate for appraisal compliance is 90%. 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 65%. This year so far, the overall appraisal rates was 96% (as at 30 November 2018).

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 30 November 2018)	% appraisals (1 April 2017 to 31 March 2018)
CRHT East South Staffs	29	29	100%	83%
CRHT Shropshire.	29	28	97%	76%
CRHT T&W	25	25	100%	67%
CRHT West South Staffs	23	20	87%	36%
Core service total	**106**	**102**	**96%**	**65%**
Trust wide	**4490**	**3615**	**81%**	**88%**

The trust's target rate for appraisal compliance is 90%. 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%. As at 30 November 2018, the overall appraisal rate was 50%.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 November 2018)	% appraisals (1 April 2017 to 31 March 2018)
CRHT East South Staffs	1	1	100%	100%
CRHT Shropshire.	0	0	0%	100%
CRHT T&W	2	0	0%	100%
CRHT West South Staffs	1	1	100%	100%
Core service total	**4**	**2**	**50%**	100%
Trust wide	**137**	**77**	**56%**	**80%**

Multidisciplinary and interagency team work

All the teams we visited held multidisciplinary team meetings to ensure patient safety and develop patient care plans. These meetings included a diverse range of professionals such as psychiatrists, social workers and nurses. These professionals had specific roles within the team

and brought together their skills in the best interests of the patient. We observed multidisciplinary staff in their work, conducting handovers and updating each other on patient risk, including information about patients' physical health and any safeguarding concerns. Caseloads were discussed daily and included the planning of liaison with other professionals including GPs. Staff routinely contacted GPs by telephone to inform them of patient assessment outcomes and always followed this up by letter. The management of access to acute inpatient beds was the responsibility of the crisis and home treatment teams and staff had regular discussions across the teams concerning any patients waiting for admission or discharge from inpatient services.

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. 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.

As of 30 November 2018, 69% 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 for inpatient and community staff and renewed three years.

Health-based place of safety

Staff at the dedicated suites for the reception and assessment of service users bought to the trust under Section 136 of the Mental Health Act had received training on the act and on the 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. Staff completed a Section 136 assessment record which included monitoring information. The monitoring form included information on the time of detention under section 136 and the time the assessment concluded. The trust had detained 819 patients from 1st January 2018 to 20th March 2019. Of these, 13 patients were held for more than 24 hours (1.6%). However, we saw that these detentions were clinically appropriate extensions and were made under the legal power to extend detention by 12 hours for reasons of patient intoxication or for difficulties in locating a bed when a patient required inpatient treatment. During normal office working hours the Approved Mental Health Professionals for the day are based with the Access Service which has improved the responsiveness and supported least restrictive approaches to Mental Health Act assessment requests.

Good practice in applying the Mental Capacity Act

As of 30 November 2018, 99% of the workforce in this service had received training in the Mental Capacity Act Level 2 (this was the only Mental Capacity Act course listed in their Provider Information Return data). The trust stated that this training was mandatory for all services for inpatient and community staff and renewed every three years. All staff said they could access and refer to trust's policy on the Mental Capacity Act (MCA) and we found evidence of the recording of mental capacity within the care notes we reviewed recording whether patients needed support in decision making and or when they lacked capacity and decisions had been made in their best interest. Staff told us they knew where they could get advice regarding the MCA and spoke

knowledgably of the key principles of assessing patient capacity. All services ensured that patients had access to an Independent Mental Health Advocacy IMHA service.

Health based places of safety

All staff we spoke to at the places of safety suites understood the Mental Capacity Act, had received training and were aware of the trust policy and where to find it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We accompanied a member of staff on a visit made to a patient in their home. The member of staff displayed good interpersonal and therapeutic skills. The staff member also signposted the patient to partnership health and social care agencies and offered help in liaising with their GP. Other staff we interviewed had good specialist knowledge of substance misuse, domestic abuse and other issues and offered caring support for patients experiencing these issues. We interviewed five other patients who all stated how caring staff were in their dealings with them. We observed staff offering high levels of care whilst completing detailed assessments in a sensitive manner.

Staff supported patients to understand and manage their care, treatment or condition by spending time listening to their individual concerns, likes and dislikes. Treating patients in their homes helped to avoid unnecessary hospital admissions and staff sustained this by ensuring they maintained good therapeutic and professionally friendly relationships with them.

Staff we interviewed told us that they would be confident to raise concerns about disrespectful, discriminatory or abusive behaviour towards patients and said they had no concerns that there would be negative consequences in doing so as the trust was a transparent organisation.

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

Patients told us they were offered a range of treatment options and that they felt involved in the care they received. 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. Staff also left carbon copies of patients care plans with the patient for reference after their first visit to them. Teams asked for feedback about their service through questionnaires and an advocacy service was available for patients. Staff also attended a service user involvement forum where service users were actively involved in providing feedback to the trust and influencing changes.

Health-based place of safety

We were unable to observe a patient assessment at either of the health based places of safety or speak to any previously assessed patients. However, we observed a role play between staff of an admission to the place of safety in Stafford. During this demonstration we observed staff to be mindful of the need to be sensitive with patients in crisis. We saw that processes were in place to support patients with their clinical needs. Staff also confirmed that 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. We found the facilities were favourable to patients' privacy and dignity and much improved since our last inspection.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed and all carers were offered an assessment of their needs in caring for someone experiencing mental health difficulties. Staff at Stafford were in the process of auditing against standards for work with carers using a recognised audit tool.

Heath-based place of safety

Staff regularly sought feedback from service users and told us that the feedback they received was good.

Is the service responsive?

Access and discharge

The Midlands Partnership Foundation Trust Crisis and Health based Places of Safety services took referrals twenty-four hours per day, seven days a week for every day of the year. The trust measured the teams' performance against the standard of a four-hour response time and telephone call within one hour. All crisis care plans were for 72 hours and then reviewed. The services did not have waiting lists, had clear referral criteria and did not exclude patients who needed treatment.

The trust call centres responded promptly when patients telephoned the service. However, at the Lichfield access team we were told that out of hours patients could wait up to 20 minutes to speak to a qualified member of staff. Both access teams had call centres with enhanced systems to monitor telephone calls coming in and wait times. Calls were answered in the first instance by specially trained administrators who then passed the calls to qualified staff when available and according to priority.

Staff used a validated risk assessment tool to prioritise all referrals and treat those in most urgent need and prevent admission to hospital if possible. Allocated key workers prevented the number of non-attendances for appointments with teams by keeping in regular contact with patients and understanding when the best times were for appointments and telephone contact. Other initiatives providing flexibility and convenience for patients included Stafford Home Treatment team's pilot project, offering clinical follow up appointments to patients discharged from the wards. These appointments were offered to patients who were not known to the team, within seven days of their discharge from hospital. Staff told us this initiative helped prevent repeated patient admissions. Stafford Home Treatment team also offered direct patient access to the team seven days after discharge. This was to support patients who, in hindsight felt they required a little more support.

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 signposted patients to use technology by providing web site links to independent sources of support and for further information and advice.

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 a focus on high quality communication between teams and the inspection team saw staff from different teams working in open plan offices ensuring effective communication across clinical pathways that included Intensive Life Skills Team (ILS), Learning Disabilities (LD), Community Interventions Pathway (CIP), Improving Access to Psychological Therapies (IAPT), Psychosis and Memory services.

Health-based place of safety

There were clear referral criteria for the trust's health based places of safety and none of the trust facilities excluded any individuals. This included patients with substance misuse problems, who were treated with compassion and skill by properly trained clinical staff. Staff ensured assessments were completed within three hours of the detention at the place of safety commencing. This was in accordance with Royal College of Psychiatrists recommendations. Staff also secured extensions to detention periods and assessments when necessary and continued with assessments when the patient was fit to do so.

In Telford teams were piloting a police liaison service and attempting to reduce the number of referrals to the health based places of safety under section 136 of the Mental Health Act. This involved staff working shifts from 6pm-2am, with the police, to triage patients in crisis at an alternative safe place, rather than the trust's place of safety. The police and support workers saw patients at agreed venues and the crisis team were then called to assist. At the time of inspection, a full evaluation of the initiative was not available. However, emerging data showed a 16% drop in the requests to go to a trust place of safety suite for a full Mental Health Act assessment. Informal patient feedback was that these alternative places of safety were safe and comfortable. Staff referred to the redesigned clinical pathways, from these places of safety, in the usual manner.

Facilities that promote comfort, dignity and privacy

Staff visited most patients at home. However, patients could also attend appointments and self-refer to the two access teams in Lichfield and Shrewsbury. These facilities at both these venues 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

Both the trust's place of safety suites was adjacent to acute wards and each suite was secure and comfortable and patients were easily observable in line with the place of safety observation policy. The suite at Stafford provided a reception room with three comfortable bedrooms. Both suites provided showering facilities. There was also a pleasant and secure outside recreation area at Stafford. Equipment and furniture in both suites were secure and complied with all health and safety standards. Entrances at both sites were discrete and suitable for disabled patients.

Patients' engagement with the wider community

All crisis and health based places of safety services we visited had established links with independent health and social care sector organisations in conjunction with the trusts community mental health care pathways. 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. Stafford home treatment team had a dedicated substance misuse support worker who liaised with local substance misuse agencies. Senior managers told us they had actively supported shifts in attitude towards patients with substance misuse problems. This support included providing specific guidance to staff, backed up with collated research evidence. Staff helped patients develop skills, knowledge and confidence in their social and family relationships and to maintain links with people that mattered to them.

Health placed place of safety

Staff signposted patients, from both places of safety, to 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 we spoke to considered 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 told us that they 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.

The inspection team found that access for disabled patients was available throughout the service's team bases, where patient access was necessary. Staff also provided information leaflets on mental health problems, treatments and local services and displayed these in-patient areas. Some leaflets were available in different languages or could arrange for translation on request. Staff could access interpreters and signers for patients if necessary.

Health-based place of safety

People with a disability could access both health-based places of safety suites through discreet entrances and all their facilities were suitable for patients 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.

People with a disability could access both health based places of safety suites through discreet entrances and all their facilities were suitable for patients 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 did not receive many complaints but acted on feedback when they received it from patients and carers. Staff discussed the trust wide outcomes of complaints at team meetings and all staff participated in developing local actions in response to these. We saw posters informing patients how to make a complaint and patients told us they felt confident to make a complaint if necessary. This service received five complaints across all the teams between 1 October 2017 and 30 September 2018.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
CRHT South Staffordshire East	2	1	1	0	0	0	0	0
136 Suite St Georges	1	0	0	0	0	0	1	0
CRHT Telford and Wrekin	1	0	0	0	0	0	1	0
CRHT South Staffordshire West	1	0	0	0	0	1	0	0
Total	**5**	**1**	**1**	**0**	**0**	**1**	**2**	**0**

This service received 29 compliments during the last 12 months from 1 October 2017 to 30 September 2018 which accounted for less than 1% of all compliments received by the trust.

Is the service well-led?

Leadership

Managers we interviewed communicated effectively with their staff and demonstrated key skills of good leadership. We saw clear communication of performance expectations and staff responding to this positively by demonstrating their enthusiasm for their work. Managers provided regular feedback to staff on their work with patients. There was a strong sense of collaborative working among staff and their managers and an obvious mutual respect between them. It was evident that managers provided ongoing help, training and guidance to staff and this fostered good working relationships. This way of working had a clear benefit to patients because staff were positive and passionate in providing services. Senior staff encouraged staff to innovate and we saw examples of how staff had continued to enhance the redesign of the trusts community pathways by working together in the same buildings and meeting regularly to make patients' treatment and care as smooth as possible. Leaders demonstrated the right skills and abilities by placing strong emphasis on good working relationships between professional disciplines and partnership work with independent agencies. Leaders also offered coaching, mentoring and extra training to help staffs continual professional development.

Vision and strategy

Staff we spoke to had recently been part of a merger between trusts and we found that staff were enthusiastic about their contribution to the vision and values of the new organisation. The trust had undertaken a staff engagement programme and many staff had been involved and provided feedback to the trust board. Staff we spoke to expressed clearly that they put their patients and colleagues at the centre of their work, were genuinely passionate about improving people's health and wellbeing and made continued efforts to work in partnership with others to deliver better care. We saw that the trusts vision of integrating its crisis and health based places of safety services seamlessly with its community pathways had made good progress and staff were applying the values of the new trust to this work.

Health based place of safety

Managers maintained good working relationships with partnership agencies to ensure sustained good quality care for patients using the places of safety. These agencies included the police, commissioners and the local authority and innovative work had started with these partners to develop alternative places of safety.

Culture

Staff told us they felt supported and valued by senior clinical managers and the inspection team saw a consistent drive within all the teams to continually enhance and improve their work with colleagues delivering the community pathway services. Staff within the crisis and health based places of safety teams demonstrated this positive culture throughout all services we visited. This was actively supported and promoted by senior managers we talked to. Managers of all services said they felt positive about working for the new trust. We observed that the morale was good and that the merger between trusts had been managed well from the perspective of most staff.

Staff told us they knew how to use the whistle-blowing process and felt able to raise concerns without fear of retribution. Staff sought guidance and support from other disciplines within the team when they needed it and regularly discussed quality improvement initiatives within their teams and felt confident to suggest improvement.

Managers demonstrated a good understanding of how to manage the poor performance of staff by providing support in understanding the definition of targets and goals for service delivery in the

context of a newly formed trust. However, managers did not inform us of any poor performance issues at the time of inspection.

Staff 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.

We were informed of long term sickness at some bases. However, staff sickness rates were not high and average for the trust. All staff had access to support for their own physical and emotional health needs through an occupational health service.

The inspection team were not informed of any specific staff recognition schemes, but staff told us that managers showed their appreciation for their hard work during supervision and at meetings. Staff said they felt valued as part of the trust and although they often worked very hard they felt positive about work and motivated to continue performing well.

Governance

Services we visited had systems in place to ensure clinicians and managers were jointly accountable for patient safety and quality care. Staff regularly reviewed policies and procedures to ensure patient safety and quality to ensure patients were assessed quickly following referral and triage and there were no waiting times. Staff knew how to report incidents and subsequent learning was clearly embedded in team meetings and through follow up of serious incidents. The trusts systems and processes ensured that all staff understood the key findings from investigations and reviews of deaths, incidents, complaints and safeguarding alerts. Staff participated in clinical audits of care plans and of their work with carers.

Staff clearly understood the importance of establishing strong working arrangements with the redesigned community pathways teams to fully meet the needs of their patients. Equally strong emphasis was placed on working with independent health and social care partners.

The trust used a systematic approach to continually improve the quality of its services and acted on results. Staff told us about special events they had attended to discuss the improvement of services. These were sometimes led by a facilitator and were part of an overall program of continuous improvement led by the trust who placed an emphasis on celebrating learning and success. Other means of including staff in governance included events named ‘report outs’ which were used to share success achieved through rapid improvement exercises. These stories were also communicated through the trust’s newsletter.

Management of risk, issues and performance

Staff made sure that risk management was at the centre of their work and supported by accurate, timely incident reporting. Risk registers were in place across the teams available to all staff. Staff we spoke to knew they could escalate concerns at team level and participated in effective processes to reduce and remove locally identified risks.

All services participated in the trusts planning for incidents and emergencies that could affect health or patient care as part of its statutory Emergency Preparedness, Resilience and Response (EPRR) work.

Information management

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 was accessible and easy to use. Any clinical information kept on paper was kept confidential and staff undertook regular training in information governance. Trust systems collected data from crisis and health based places of safety services. 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.

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 specific feedback forms to get opinions on their services from patients and their carers. Patients could complete these at the time of their appointment or at any other time through their treatment journey.

Staff involved service users and carers in the planning of services and had recently consulted on the naming of certain care pathways. This was ongoing work and led by nominated staff within the teams. Service users also knew they could go directly to the senior leadership team to discuss service delivery.

Staff engaged with external stakeholders such as commissioners regarding local priorities and staff regularly worked with independent stakeholders to improve services.

Learning, continuous improvement and innovation

Staff we interviewed were committed to quality improvement and staff knew that there was also commitment to this at the highest levels of the trust. Managers and staff regularly worked together to identifying where improvements needed to be made.

The trust's crisis resolution and home treatment teams were in the process of or had completed the Royal College of Psychiatrists Home Treatment Accreditation Scheme (HTAS). The teams were judged against HTAS standards and quality improvement measures that included measuring service provision and assessment, care planning and discharge. The accreditation scheme was self, and peer assessed and approved once the teams had provided satisfactory evidence to the multidisciplinary accreditation team, made up of professionals and service user and carer representatives.

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
Home Treatment Accreditation Scheme	CRHT West, CRHT East. CRHT Telford and Wrekin and CRHT Shropshire have achieved Home Treatment Accreditation Scheme (HTAS) accreditation	

Specialist community mental health services for children and young people

Facts and data about this service

Location site name	Team name
Argyle Street Clinic	CAMHS South Staffs - East
The Bridge	CAMHS South Staffs - West
Coral House	Access and Early Intervention
Coral House	Core Mental Health & Complex Care Team
Coral House	Specialised Care Team
Coral House	Emotional Health and Well-Being 0-25 Shrop/Telf
The Bridge	CAMHS Early Years' Service
St Michaels Court	CAMHS Intensive Outreach Service
161 Eccleshall Road	CAMHS Sustain Plus
The Telford, Langley School	Core Mental Health CAMHS, Looked after children & Crisis Home Treatment Children

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 service safe?

Safe and clean environment

Staff did not complete regular risk assessments of the care environment and were unsure as to who would complete them. Staff did not know about their environmental risk assessment, this meant staff had not considered all risks including areas accessed by their patients. The last environmental assessment for buildings in Shropshire were carried out in August 2017. In Staffordshire the health and safety audits were completed in November 2018. Assessments did not cover all areas of the building where people were seen and did not accurately reflect the environment.

Interview rooms at Telford in Shropshire were fitted with alarms with no alarms fitted at the other sites and staff were not equipped with personal alarms. However, this did not compromise safety as staff complied with the trust's safe working procedures. There were safety measures in place to ensure staff and young people's safety. This included secure entry and exit to therapeutic areas and staff would invite other staff to attend meetings with them if they had concerns. Although there had been no incidents where alarms had been needed, there were plans to issue staff with alarms.

All of the bases had specific rooms that staff used for physical examinations. The rooms contained clinical equipment such as blood pressure machines, weighing scales and height measures. In our

last inspection in March 2016 stickers to record the calibration of scales were not visible, dates were unclear, and calibration was not being monitored. We found on this inspection that this had not been addressed. There was no system in place to monitor the scales and blood pressure machines at all sites. Senior managers in Staffordshire told us there was a trust maintenance plan to address this in April 2019.

All areas were clean, had good furnishings and were well-maintained. Although the clinic and interview rooms were very clean, there were no cleaning schedules in place that demonstrated the premises were cleaned regularly. There was a toy cleaning rota in place and we saw staff using antibacterial wipes to clean toys after use.

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

Safe Staffing

Services had employed staff with the right qualifications, skills, training and experience to keep children and young people safe and provide the right care and treatment.

Service managers and team leaders had agreed staffing levels and skill mixes that met the clinical requirements for each team. The service had clinical pathway teams that underpinned the teams staffing structure of children and young people's mental health services. In Staffordshire the teams included core Children and Adolescent Mental health service's (CAMHS) east and west, eating disorders, outreach, looked after children and early years. In Shropshire the teams included crisis and brief intervention, eating disorders, core CAMHS, neurodevelopment, learning disability, early years and looked after children. In addition, the children and young people's mental health service had an access team that provided a single point of access to children and young people. Each of the teams had clinical leads in post. Managers adjusted staffing levels and skill mix to respond to changes in services and in the needs of their local population. However, since January 2019 there had been no staff within the attention deficit hyperactivity disorder (ADHD) pathway. This resulted in growing number of referrals, complaints and concerns raised by families of the young people.

As of 28 February 2019, this core service had a total non-medical staffing establishment of 69 whole-time equivalent posts for Shropshire and 93 whole-time equivalent posts for Staffordshire. Teams in Staffordshire had no vacancies and Shropshire had 2.6 vacant posts, the service was recruiting to fill these vacancies at the time of our inspection.

There was no recognised tool to monitor caseloads, however managers ensured that staff had manageable caseloads to help ensure safe and effective practice. Staff said that they were well supported by managers in managing their caseloads. They confirmed managers reviewed and monitored caseloads within staffs' managerial supervision. Each team held meetings to monitor and reassess caseloads to ensure fairness and equity of allocations. In Shropshire, medical staff and non-medical prescribers had caseloads of an average of 120. Managers told us this was a result of the inherited caseloads from the previous trust, staff were working hard to reduce caseloads, reviewing medication and offering alternative therapies.

Managers did recognise that staffing was lower than the aspirational national standard. Staff we spoke with said that they were concerned that staffing was insufficient, and that future sickness or leave could affect the service provision. Managers ensured appropriate cover arrangements for absences and vacancies. Where possible, staff planned cover from within their own teams to help ensure continuity of care. Staff gave examples of contacting patients in advance to inform them of any changes to their clinician. The service offered staff overtime and used bank staff. The service used one agency staff member to cover clinical (non-medical) posts. The table below shows that in the 12 months to 30 September 2018, the service used bank staff to fill 7% of shifts, another 2% of shifts were not filled. However, due to the number of children and young people requiring medical intervention meant that the service relied on locum psychiatrists to fill the gaps.

This core service has reported a vacancy rate for all staff of 8% as of 30 September 2018.

This core service reported an overall vacancy rate of 11% for registered nurses as of 30 September 2018.

This core service reported an overall vacancy rate of -4% (over establishment) for healthcare assistants as of 30 September 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Team name	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Specialised Care Team	4.6	10.0	46%	1.0	1.0	100%	9.1	19.4	47%
CAMHS Sustain Plus	1.8	2.2	82%	0.6	1.6	38%	3.1	11.4	27%
CAMHS South Staffs - East	0.5	5.6	9%	0.3	11.3	3%	1.2	34.2	3%
CAMHS Early Years' Service	0.0	1.2	4%	0.0	3.2	0%	0.2	7.1	3%
CAMHS South Staffs - West	-0.5	6.1	-8%	-0.6	7.1	-8%	0.6	30.7	2%
Emotional Health and Well-Being 0-25 Shrop/Telf	0.0	2.0	0%	-2.9	13.9	-21%	0.0	23.4	0%
CAMHS Intensive Outreach Service	1.0	3.0	33%	-0.1	0.6	-17%	0.0	5.6	0%
Core Mental Health & Complex Care Team	-1.7	8.4	-20%	-	-	-	-0.4	14.6	-2%
Access and Early Intervention	0.1	13.4	1%	-	-	-	-0.9	14.4	-6%
Core service total	**5.9**	**51.9**	**11%**	**-1.6**	**38.7**	**-4%**	**12.9**	**160.9**	**8%**
Trust total	**140.5**	**1969.7**	**7%**	**146.8**	**1424.0**	**10%**	**536.1**	**5645.8**	**9%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 30 September 2018, of the 107196 total working hours available, 2% 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 2% of available hours for qualified nurses and less than 1% of available hours were unable to be filled by either bank or agency staff.

Team name	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Emotional Health and Well-Being 0-25 Shrop/Telf	15611	2183	14%	1618	10%	269	2%
CAMHS South Staffs - East	11859	114	1%	0	0%	10	<1%
Access and Early Intervention	21875	7	<1%	0	0%	0	0%
CAMHS Sustain Plus	3850	0	0%	0	0%	0	0%
CAMHS South Staffs - West	12849	0	0%	0	0%	0	0%
Core Mental Health & Complex Care Team	13197	0	0%	0	0%	0	0%
Specialised Care Team	19885	0	0%	0	0%	0	0%
CAMHS Early Years' Service	2153	0	0%	0	0%	0	0%

Team name	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
CAMHS Intensive Outreach Service	5917	0	0%	0	0%	0	0%
Core service total	**107196**	**2304**	**2%**	**1618**	**2%**	**279**	**<1%**
Trust Total	**3781640**	**96462**	**3%**	**38953**	**1%**	**25030**	**1%**

Between 1 October 2017 and 30 September 2018, of the 7067 total working hours available, 7% were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

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

In the same period, agency staff covered 0% (none) available hours and less than 1% of available hours were unable to be filled by either bank or agency staff.

Team name	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Emotional Health and Well-Being 0-25 Shrop/Telf	1697	0	0%	0	0%	0	0%
Specialised Care Team	1631	0	0%	0	0%	0	0%
CAMHS Early Years' Service	3739	0	0%	0	0%	0	0%
CAMHS South Staffs - East	0	483		0		8	
Access and Early Intervention	0	0		0		0	
CAMHS Sustain Plus	0	0		0		0	
CAMHS South Staffs - West	0	0		0		0	
Core Mental Health & Complex Care Team	0	0		0		0	
CAMHS Intensive Outreach Service	0	0		0		0	
Core service total	**7067**	**483**	**7%**	**0**	**0%**	**8**	**<1%**
Trust Total	**1847533**	**220632**	**12%**	**78422**	**4%**	**38181**	**2%**

This core service had 26.1 (18%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Team name	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
161 Eccleshall Road	CAMHS Sustain Plus	8.3	3.7	39%
Coral House and Langley School	Emotional Health and Well-Being 0-25 Shrop/Telf	23.4	11.3	38%
Coral House	Specialised Care Team	10.3	2.5	29%
The Bridge	CAMHS South Staffs - West	30.2	4.6	15%
Coral House	Core Mental Health & Complex Care Team	15.0	1.5	12%

Location	Team name	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Coral House	Access and Early Intervention	15.3	0.6	6%
Argyle Street Clinic	CAMHS South Staffs - East	33.0	1.9	5%
The Bridge	CAMHS Early Years' Service	6.9	0.0	0%
St Michael's	CAMHS Intensive Outreach Service	5.6	0.0	0%
Core service total		**147.9**	**26.1**	**18%**
Trust Total		**5109.7**	**679.3**	**14%**

The sickness rate for this core service was 4.5% between 1 October 2017 and 30 September 2018. The most recent month's data (30 September 2018) showed a sickness rate of 3.0%.

Location	Team name	Total % staff sickness (at latest month)	Ave % staff sickness (over the past year)
Coral House	Core Mental Health & Complex Care Team	3.7%	8.3%
The Bridge	CAMHS South Staffs - West	3.1%	5.7%
Coral House and Langley School	Emotional Health and Well-Being 0-25 Shrop/Telf	3.3%	5.7%
Coral House	Specialised Care Team	0.5%	3.8%
Coral House	Access and Early Intervention	2.8%	3.7%
St Michaels	CAMHS Intensive Outreach Service	0.0%	3.3%
Argyle Street Clinic	CAMHS South Staffs - East	3.8%	2.8%
161 Eccleshall Road	CAMHS Sustain Plus	0.6%	2.0%
The Bridge	CAMHS Early Years' Service	5.8%	1.6%
Core service total		**3.0%**	**4.5%**
Trust Total		**4.7%**	**5.2%**

Between 1 October 2017 and 30 September 2018, of the (23661) total working hours available, none were filled by bank staff to cover sickness, absence or vacancy for medical locums and 45% were filled with agency staff. Five percent of hours were not filled.

In Staffordshire there was 6.8 whole time equivalent medical staff with 8% vacancies. However, in Shropshire, there were 3.5 whole time equivalent medical staff and 34.8% vacancies. The trust had employed an extra 4 locum medical staff as there was a high number of children and young people requiring medical staff (psychiatrists) from the previous trust. This meant that the service relied heavily on locum psychiatrists.

Eight staff within Shropshire told us it was difficult to access psychiatrists, staff had no idea who was on call or when. Staff told us at times there were no urgent slots available with psychiatrists

despite this being a recommendation from the coroner in a previous investigation and serious incident. Staff told us that patients often waited up to six weeks for an urgent medic session. Young people and their carers told us they were seen by different doctors. This meant at times young people had no continuity of care and psychiatrists could not always build relationships and understand the needs of the young people better. Managers told us they recognised this problem and it was a major action point they were working through from NHS Improvement's intensive support team review.

Team name	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Emotional Health and Well-Being 0-25 Shrop/Telf	10233	0	0%	10665	104%	1200	12%
CAMHS South Staffs - East	8352	0	0%	0	0%	0	0%
CAMHS South Staffs - West	5026	0	0%	0	0%	0	0%
Core service total	**23611**	**0**	**0%**	**10665**	**45%**	**1200**	**5%**
Trust Total	**396315**	**2237**	**1%**	**38147**	**10%**	**1680**	**<1%**

Mandatory training

The compliance for mandatory and statutory training courses at 30 November 2018 was 77%. Of the 20 training courses listed, 18 failed to achieve the trust target and of those, eight failed to score above 75%.

The trust set a target of 90% for completion of mandatory and statutory training. The trust reports training on a month by month rolling basis.

All staff we spoke with during the inspection told us they were up to date with their mandatory training. Managers ensured that staff were provided with mandatory training and reported that there was an improvement in compliance since November 2018. Where staff were due to attend training, they were booked onto upcoming courses and local managers had good oversight of mandatory training 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
Manual Handling - Object	81	75	93%	✓
Safeguarding Children (Level 3)	254	229	90%	✓
Promoting Safer and Therapeutic Services	257	228	89%	✗
Equality and Diversity	362	318	88%	✗
Mental Capacity Act Level 2	130	114	88%	✗
Safeguarding Adults (Level 1)	359	311	87%	✗
Safeguarding Children (Level 2)	359	312	87%	✗
Conflict Resolution	104	90	87%	✗
Local Induction	362	311	86%	✗
Health and Safety (Slips, Trips and Falls)	33	27	82%	✗

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Corporate Induction	33	25	76%	✖
Prevent Awareness	362	271	75%	✖
Fire Safety - 1 Year	362	260	72%	✖
Infection Prevention (Level 1)	278	196	71%	✖
Adult Basic Life Support	264	185	70%	✖
Clinical Risk Assessment	199	138	69%	✖
Information Governance	362	251	69%	✖
Medicine management training	91	54	59%	✖
Mental Health Act	135	68	50%	✖
Manual Handling - People	263	99	38%	✖
Total	**4650**	**3562**	**77%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

On our last inspection in March 2016 of the Staffordshire services we found that practitioners did not always complete or update risk assessments. On this inspection, we found that there were inconsistences in appropriate recording of patients' risks. Across Staffordshire we looked at 16 records and found 13 to have an up to date risk and personalised risk assessment which then fed into the patient care and management plans. However, in Burton, we found two records had no completed risk assessment and one further record had not been updated for a year.

In Shropshire, we looked at 21 records, four records had no completed risk assessments. Five records had risks highlighted within the progress notes however they contained no updated risk assessments to reflect the risks. Staff did not regularly document risk with enough detail or narrative to support the risks, for example, a young person who had made several suicide attempts within a two-month period had been flagged as medium risk of deliberate self-harm, with no information to understand and manage the risks.

For one young person with several risks detailed in progress notes, the risk assessment had not been updated post discharge from the ward, exploitation from others was flagged as low, despite concerns about being exploited by people online and there was no narrative to explain why. There was no crisis plan in place. Following a multidisciplinary team meeting a decision was made to reduce risks from high to medium with no documentation of why the reason had been made. Upon speaking to staff involved with this patient it appeared that all staff were fully aware of all risks posed however the documentation was poor.

Staff completed risk management crisis plans. We saw plans were personalised to the patient and in Staffordshire the outreach team had renamed their crisis plans as 'keeping well' plans to provide a more positive message. The service's Youth Participation Group had also produced a booklet about relapse and crisis management which was handed out to patients.

Management of patient risk

The access team based in Shrewsbury triaged all new referrals from professionals and would direct them to either internal or external services, as appropriate. When an initial referral came through, administration staff completed initial screening and any urgent or eating disorders referrals would be passed directly to a clinician. However, staff told us a clinician could take up to two to four days to make telephone contact with non-urgent referrals. During the inspection we saw staff had not contacted new referrals for up to seven days. This meant that new referrals had not received a clinical triage of risks by an appropriately qualified practioner for this length of time.

The system used would not flag risks, but number of days patients were waiting for the initial contact.

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. In Staffordshire staff identified patients waiting 15 weeks or more for treatment who were then reviewed by the managers. Patients and or their families were then contacted by a clinician to review risk. If the patient's risk had increased, then the patient's appointment was bought forward.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. All staff signed in and out of the premises. For visits to unfamiliar patients in their homes, staff attended with another member of staff. In Staffordshire, the outreach team had created a robust risk assessment of lone working which identified potential hazards and detailed how to mitigate those hazards including having a buddy system. In Shropshire staff in the crisis team had a popular web-based application group they used to check in with their colleagues as they were not always based at the same site. This enabled staff to see where they were and what they were doing.

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 at risk 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 at risk, 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 46 safeguarding referrals between 1 October 2017 and 30 September 2018, one concerned adult and 45 for children.

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff knew how to make a safeguarding referral and did so when appropriate. The trust had an up to date safeguarding policy to reflect current guidance and practice. We also found that the service worked very closely with other key agencies such as children's social services to ensure the protection of children and families. Staff had access to support and advice from the trust's safeguarding team and described them as very knowledgeable and helpful.

Staff could give examples of how to protect children and young people 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.

The trust has submitted details of two serious case reviews commenced or published in the last 12 months (1 October 2017 to 30 September 2018). None related to this core service.

Staff access to essential information

Staff used electronic patient records and they kept detailed records of patients' care and treatment. Records in Staffordshire were clear, up-to-date and easily available to all staff providing care. It was also accessible to all relevant staff when children and young people moved between teams. However, the services in Shropshire had gone through the process of transferring from a paper system to an electronic record system in December 2017. All new referrals had a completely electronic file. Existing cases had had the information scanned though electronically.

Staff reported that patients' historical information was not easily accessible to staff when they needed it, as it had not been scanned through in a chronological manner. We saw an example in the looked after children team where a patient had 1300 pages of paper record scanned through, not in order, not in any category, meaning staff were unable to access information in a timely manner.

Medicines management

The service did not store or administer medication on site.

Psychiatrists prescribed in line with National Institute of Health and Care Excellence guidance and there was significant oversight and review of prescribing by pharmacy and the medicines committee. The psychiatrists reviewed and monitored any side effects of the medication in line with national guidance. There were non-medical nurse prescribers in the service who prescribed within their scope under the regular supervision of psychiatrists. Both medical and non-medical prescribers retained a log of their use of prescriptions and prescribing details, for monitoring purposes.

Staff gave young people and their families' easy read information about their medication and possible side effects. Records showed reviews of patients on certain medications included a physical health check.

Track record on safety

Between 1 October 2017 and 30 September 2018 there were no serious incidents reported by this service.

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 none 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.

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 five 'prevention of future death' reports sent to the trust. Two of these related to this service and measures were in place that prevented same mistakes happening again. Services followed national safety guidance systems to prevent serious incidents such as never events happening.

The service managed incidents well. Staff recognised incidents and reported them appropriately. Staff knew what incidents to report and how to report them. Staff said they had recently completed incident forms when they have had to cancel appointments due to non-clinical reasons such as not being able to find rooms. Staff in Staffordshire gave an example of a receptionist post being reinstated because of an incident where a member of the public became unconscious in an empty hall. Incidents were discussed at each location's weekly team meeting. However, some staff in Shropshire reported that they often did not receive feedback following logging of incidents, no debriefs were taking place and no shared lessons learned with the whole team and the wider service. The service manager had recently introduced a team meeting template that was in line with CQC key lines of enquiry as a way of creating a clear structure, to encourage consistency within the teams and promote shared learning. This was still in its infancy stage, staff were not aware that this had been introduced.

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

Is the service effective?

Assessment of needs and planning of care

We looked at 37 care records across the core service and saw staff completed a comprehensive mental health assessment. Staff assessed the physical health of children and young people and were able to request physical investigations such as bloods, ECG (echocardiogram) if required.

In Staffordshire we reviewed 16 care records and found that staff developed care plans that met the identified physical and mental health needs of children and young people. The care plans were recovery focused, holistic, and updated appropriately at reviews. They contained sufficient information to support safe care for young people and children. For example, they covered triggers, things the patient could do to help themselves, a list of what would not help and important people. Additionally, the service used smiley face symbols to identify emotion which then directed the patient to specific sections of advice. The outreach team included things important to the patient such as pictures of people or places important to the patient and gave examples of turning negative worded songs into positive reinforcement.

Of the 21 records we reviewed in Shropshire eight of these had no care plans and in seven records the care plans were not up to date. We saw that once a patient was referred to Healios (their partnership agency) staff would not record an updated care plan from the date of referral. Where the care plans were up to date, most were not holistic, patients' needs were not captured and lacked detail. We saw an example of a care plan for a patient who had made several suicide attempts, had been an inpatient and had safeguarding issues, had one line stating, "to meet with Community Mental Health Team" with no reference to the current issues or other agencies involved with the patient. There was no record to evidence that the young people had been given a copy of their care plan, the young people and carers we spoke to told us they did not know what was in their care plans. However, progress notes were of a good standard and captured detail but were not consistently pulled through to the care plan.

Best practice in treatment and care

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
OCD NICE Audit Report	CAMHS East and West	Clinical audit	June 2018	Discussion with Clinical teams (through team meetings including the CAMHS Business meeting) improvements required for: - Clinical notes indicate that a Multidisciplinary review occurred and identified that an SSRI in addition to psychological treatment was explored - Clinical notes indicate clinical outcome of the intervention offered Discussion with Consultant body (CAMHS) to agree the appropriate standard for 'careful monitoring' and dissemination to prescribers in CAMHS of written guidelines. A re-audit is planned for 2019.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Antidepressant Prescribing for Depression in CAMHS	CAMHS (Stafford and Cannock)	Clinical	February 2018	Record Keeping to be added to the weekly prescribers meeting agenda to discuss documentation when clinicians deviate from NICE guidelines and why fluoxetine is being prescribed. Recent journal evidence to be circulated among prescribing clinicians.

Staff provided a range of care and treatment interventions suitable for the needs of the patient group. The interventions were those recommended by and were delivered in line with National institute for Health and Care Excellence guidance. Staff provided family therapy, cognitive behavioural therapy, eye movement desensitisation and reprocessing, dialectical behaviour therapy, solution focussed therapy, art therapy and psychology.

In Shropshire there was a legacy of the domination of the medical model before the service transferred. The medical model focused on the physical and behavioural symptoms of mental illness and sought to remedy those problems through the use of medicines. This was done without proper reference to the national guidance that promotes psychological and behavioural approaches to childhood distress. At that time there were around 1,400 children and young people on the caseload of medics, predominantly locum staff, a substantial proportion of whom were being prescribed psychotropic drugs. A high percentage of these were being treated for 'conduct disorder', autism or Attention deficit hyperactivity disorder (ADHD). On this inspection we found that, following some work by the NHS Improvement's intensive support team physical health checks had been undertaken for all those children and young people. There had been no duty of candour incidents or issues with medication identified. There was a robust process in place for the review of physical health when patients were prescribed medication. There were now more medical staff in post to work with families in deprescribing medication and offering psychological therapies if appropriate.

The services worked towards a thrive model of care which is an integrated model of care focusing on, person centred, and needs led approach to delivering mental health services for children, young people and their families. Two staff members in Staffordshire had completed the Improving Access to Psychological Therapies program to deliver several psychological therapies.

In Shropshire, we reviewed two autism diagnostic assessments and could not find documented evidence to show that during the diagnostic process the need for a speech and language input or assessment had been considered or undertaken. Staff told us that there was no speech and language therapist in the team currently due to maternity leave, but they could access one from the community. According to National institute for Health and Care Excellence guidance, for assessment of autism in children and adolescents, a multidisciplinary group which includes, paediatrician and/or child and adolescent psychiatrist, speech and language therapist and clinical and/or educational psychologist, should be set up as part of the standard assessment process. There was no documentation to suggest that such a team was in place nor that there had been any meeting with parents to feedback the results of the assessment, which had been undertaken using an online tool by another provider. Staff told us parents were given verbal feedback if they requested. The documentation of the process was poor and not in line with National institute for Health and Care Excellence guidance.

Staff ensured that patient's physical health needs were being met. In most cases, GPs monitored any physical health problems that children and young people had. Staff from the core service monitored children and young people's physical health especially if they prescribed medicines to them or if they had an eating disorder. The eating disorders team worked with a dietician who oversaw the physical health checks. The learning disability team held joint appointments with paediatricians for young people whose needs overlapped. For example, pain management or investigation of an underlying infection of someone who struggles to communicate verbally.

Staff supported patients to live healthier lives. Staff gave young people and their families information about healthy eating, sleep, good hygiene and selfcare.

We reviewed seven records in Shropshire and did not see evidence of the use of outcome measures. Most staff told us they did not use outcome measures. However, in Staffordshire we saw evidence of outcome measures in the 16 records we reviewed. Staff had good knowledge of the outcome measures they used, for example they used score cards and graphs that showed patients progress.

Staff used technology to support patients effectively. In Shropshire staff issued young people and their families with information regarding online therapy programmes such as Healios, and Kooth, a text messaging service. Services had their own designed websites, in Shropshire (known as Bee U) in Staffordshire (known as CAMHS you are not alone). The websites contained interactive material for young people and their carer's, presented in an engaging way.

Staff in Shropshire told us they were not involved in any clinical audits and were not aware that any audits were taking place. There was no evidence to suggest that staff participated in work that helped improve the service. However, the service manager told us there had been a health records audit and as part of that learning, staff had been advised to re-read the care plan policy. In Staffordshire staff participated in several clinical audits and gave examples of learning that had resulted from them.

Skilled staff to deliver care

Since the last inspection the teams had employed a full range of specialists required to meet the needs of patients across the service. These included mental health and learning disability nurses, psychologists, child psychotherapists, child psychiatrists, dietician, mental health practitioners, family therapists, cognitive behavioural therapists and art therapists. The service had good access to school nurses, teachers and social workers.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of children and young people. The trust ensured that staff received the necessary specialist training for their roles. Staff gave us examples of training available to them in addition to their mandatory training. Managers identified staff learning needs via supervision and provided them with opportunities to develop their skills and knowledge.

The service provided an appropriate and detailed trust wide induction for staff. Managers provided local team induction and shadowing opportunities for new staff members. Staff we spoke with told us that the inductions were sufficient and equipped them with the skills and knowledge needed to work in the service.

Staff met in their teams regularly. Each team had their own agenda and discussed different things. The service manager told us she had recently introduced a team meeting proforma in line with CQC five key lines of enquiry, that was to be implemented in team meetings to offer consistency within the service. This was in its infancy stage and had not been implemented in the teams at the time of the inspection.

The trust's target rate for appraisal compliance is 90%. 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 68%. This year so far, the overall appraisal rate was 68% (as at 30 November 2018).

Team 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 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
CAMHS Intensive Outreach Service	5	5	100%	100%
Specialised Care Team	10	9	90%	N/A

Team 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 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
CAMHS Early Years' Service	6	5	83%	100%
Access and Early Intervention	11	9	82%	N/A
CAMHS South Staffs - East	33	26	79%	64%
Emotional Health and Well-Being 0-25 Shrop/Telf	18	14	78%	67%
Core Mental Health & Complex Care Team	13	9	69%	0%
CAMHS South Staffs - West	29	10	34%	68%
CAMHS Sustain Plus	4	1	25%	57%
Core service total	**129**	**88**	**68%**	**68%**
Trust wide	**4490**	**3615**	**81%**	**88%**

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff within this service was 71%. This year so far, the overall appraisal rates this was 71% (as at 30 November 2018).

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 30 November 2018)	% appraisals (1 April 2017 – 31 March 2018)
CAMHS South Staffs - West	3	3	100%	67%
CAMHS South Staffs - East	4	2	50%	75%
Core service total	**7**	**5**	**71%**	**71%**
Trust wide	**137**	**77**	**56%**	**80%**

The service could not provide evidence that monthly staff clinical supervision was being undertaken as per their policy. It meant managers were unable to demonstrate how they had managed the impact of incidents and discussed lessons learnt with individual staff members. However, during our inspection, we saw diary appointments and records of supervision for most teams. We found that the different teams had their own systems that ensured that supervision took place.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff we spoke with gave examples of where managers had supported them to develop and access internal and external training programmes in order to support improvement and learning in areas they had identified. Training opportunities included access to family therapy training, dialectical behavioural therapy, illicit drug user training and non-medical prescribing.

Managers could describe how they would address performance issues in line with trust policy, the human resources department supported them to manage poor staff performance and it was dealt with promptly and effectively.

Multidisciplinary and interagency team work

Staff held regular multidisciplinary team meetings in their respective teams. Teams had weekly multidisciplinary team meetings for professionals to present cases for allocation. We observed four multidisciplinary meetings, all staff discussed young people in a kind, professional and informed manner. Meetings included a review of all cases presented. In Shropshire most staff told us that

they felt the teams were disjointed despite being based in the same building, individual teams did not communicate with each other. Staff described that they felt individual teams worked in isolation. Senior managers told us they had introduced a clinical senate which was for clinical leads across Shropshire and Staffordshire to meet up and share best practice. The service had one session in January 2019 and not all staff were aware it was happening.

The teams had a number of partnerships in place with local children's services, youth services, housing, schools, voluntary charities and external services. In Shropshire the trust had formal links with Beam- a drop in service, Healios – an online therapy site and Kooth – a text messaging service. Staff, young people and their families told us that relationships between clinicians and school staff were well established. Staff worked together to manage risk and to aid young people in the school environment.

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

As of 30 November 2018, 50% 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 for inpatient and all community staff and renewed three years.

Staff had access to the Mental Health Act policy on their intranet.

Staff we spoke with were aware of their roles and responsibilities when working with patients under the Mental Health Act. The Mental Health Act was rarely used by the specialist community mental health services for children and young people. Approved mental health practitioners and section 12 approved consultant psychiatrists conducted any Mental Health Act assessments required. They could conduct these at hospital or in the community.

There were no cases of young people on community treatment orders at the time of our inspection.

Good practice in applying the Mental Capacity Act

As of 30 November 2018, 88% of the workforce in this service had received training in the Mental Capacity Act Level 2 (this was the only Mental Capacity Act course listed in their PIR data). The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The trust had a policy on the Mental Capacity Act. Staff were aware of the policy, had access to it and knew who to approach in the trust if they need support or advice.

The staff we spoke with had a good understanding of capacity and competence and could give examples of when they would need to consider a capacity assessment. Staff understood mental capacity applies to young people aged 16 years and over. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. Gillick competence is used in medical law to decide whether a child (16 years or younger) can consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff could describe the circumstances where Gillick competence would be assessed and demonstrated an understanding of the interface between capacity and Gillick competence. They gave examples of working with young people around their medication and gender preferences using the Gillick competence test. In our last inspection in March 2016 we told the trust they should ensure that discussions are recorded and accessible in the patient records. On this inspection, this had not been fully addressed, in Shropshire staff did not record this in the specific area within the notes, so it was difficult to find.

Staff took all practical steps to enable young people to make their own decisions.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed staff communicating in a sensitive, caring and compassionate way in their work with young people. Positive staff interactions with children, young people and their families was evident at appointments, during telephone conversations and while they waited in the reception areas. Staff were respectful, discreet and responsive to people who needed emotional support and advice.

All staff showed commitment and motivation in their work. Staff took person-centred approach, demonstrating understanding of individual children and young people's personal, cultural, social and religious needs.

We spoke to six young persons and 13 parents and carers. All of them said that staff treated them well, listened to their concerns, and showed genuine empathy. Parents told us that staff were completely respectful, polite, caring and interested in their child's wellbeing. Families felt fully involved in their children's care and felt valued, listened to and respected.

Staff showed in-depth knowledge of their patients. They demonstrated an understanding of their client group's individual needs and were able to describe individual considerations in each case.

Staff directed patients and their families to other services, when appropriate. This included services in the community such as bereavement counselling, as well as redirection within children and young people's services.

Staff said they were confident in raising concerns about disrespectful, discriminatory or abusive attitudes and behaviour towards children and young people if witnessed. Staff were able to give examples of where they had needed to do so in order to protect the rights of the young person.

Staff maintained confidentiality of the young people and families they worked with. Staff maintained confidentiality by logging off the computer and not leaving files on desks when they were not present. Staff respected patients' confidentiality when meeting with them, for example, they took patients to private rooms for meetings and ensured they did not disclose information in front of others when in reception areas and were respectful of privacy.

Staff were flexible as much as possible in terms of matching young people with a care coordinator of the same sex, for example, where there had been a history of sexual abuse. Staff also saw young people as close to the family home as possible.

Involvement in care

Involvement of patients

Staff and patients told us they were involved in assessment and care planning. However, in Shropshire, records did not show that patients were involved in the development of their care plans. The patients and carers had not received copies and were not aware of what was in their care plans.

Staff communicated with patients in a way that they could understand. Staff used child and young-people friendly materials to help patients understand their care and treatment, with no use of jargon. Staff within Staffordshire gave patients information with their photographs on them, so patients could see who would be meeting them. When patients completed questionnaires, the staff scored those with the patients, so they could see the improvements in their health. Staff produced graphs of those scores to further highlight the improvements the patients made. Staff told us that patients looked forward to 'graph day'.

Staff routinely involved young people in recruitment of staff.

Staff enabled young people to feedback on the service. For example, young people had been consulted on the development of the children and young people website.

Staff signposted patients to local advocacy support and counselling services this was an improvement since the last inspection in 2016. We saw leaflets and posters on display in waiting areas.

Involvement of families and carers

Staff supported families and carers well. Most children and young people had parents involved in their care and treatment owing to their ages. Staff worked in partnership with parents and carers and gave them support and advice when needed.

Parents and carers told us that staff supported them well and were approachable. They showed genuine interested in their children's welfare and treated them as partners in decisions about their children's care. Staff routinely took carers needs into account at initial assessment and signposted them to appropriate services including for carers assessment if required.

Parents knew how to give feedback via the forms in the waiting room or by talking to staff. In Staffordshire, teams had patient and parent forums who fed back on service improvements. The service also sent monthly text messages asking a question of the month, the response from which was used to improve the service. For example, in Lichfield they improved the waiting area by putting colourful seats as a response from the forums.

Is the service responsive?

Access and discharge

The service had clear criteria for which patients would be offered a service. These had been agreed with the commissioners and appeared in their service specification. There were differences in access to services between Staffordshire and Shropshire, due to variation in commissioning and service configuration. Services in Staffordshire worked Monday to Friday 9am - 5pm and worked with young people aged 0-18. In Shropshire services worked Monday to Friday 9am - 5pm, with patients aged 0-25. Most staff told us they worked with children and young people aged 0-18 and they supported and prepared young people to transition into adult services when they turned 17.5 years old. Teams had a monthly transition meeting with the adult services and completed a joint assessment to assess suitability for adult services.

In the previous inspection in March 2016 of Staffordshire services, a requirement notice was issued, we told the trust to take action to reduce the waiting times and put systems in place to reduce length of wait from assessment to treatment. On this inspection, we found that the trust had developed a strategy to help address these issues. The service still had waiting lists in some of its teams, we did see evidence of active management and monitoring of waiting lists, although there were variations within the different teams. The strategy included the introduction of the access and brief intervention teams, to triage and assess new referrals.

In Shropshire, the access team took all new referrals and would direct them to the appropriate team. At the time of inspection, the access team had 98 children and young people on their waiting list. 43 children and young people had been flagged as "suspended" as staff had not been able to make contact and were waiting response. This meant 55 new referrals were waiting for triage and had not been clinically triaged for up to seven days. The system used would not flag risks, but number of days patients were waiting for the initial contact. Feedback from carers was that it had been difficult to access services as often they had to wait for long periods of time.

As of 15 March 2019, trust data showed the access and brief intervention team had 238 children and young people waiting for assessment, with longest wait at 179 days (26 weeks). 120 children and young people were waiting for autistic spectrum disorder (ASD) screening. Some children were waiting allocation to the core team as no one had capacity to take them. We were told some could be on hold for 3 - 4 months after the brief intervention team had seen them. We saw a case waiting since 22 January 2019, not able to be allocated as they needed a psychiatrist appointment

but there was no capacity. Staff told us that patients often waited up to six weeks for an urgent psychiatrist appointment.

Trust data showed there were 43 children and young people waiting for Attention deficit hyperactivity disorder (ADHD) assessments with the longest wait 277 days (39 weeks). There were 122 children and young people waiting for ASD assessments. At the time of the inspection there were no staff within the ADHD pathway since January 2019 and the managers told us they were working with commissioners to resolve this. This had been flagged on their risk register with no action plan in place. Staff informed us that they had maintained contact with the young people and their carers on the waiting list to assess risk and offer alternative interventions whilst the trust were deciding on a way forward.

At the time of inspection, there were no waiting lists for learning disability and eating disorders teams. The teams offered assessment and treatment in line with the relevant national guidelines and targets.

The core Children and Adolescent Mental health service (CAMHS) team in Shropshire had 21 children and young people on their waiting list with the longest waiting 18 weeks. In Staffordshire, the East team had 126 and West team had 74 children and young people waiting, with the longest waiting 16 weeks. The trust informed us that the waiting list report was used operationally to prevent 18-week breaches and to manage risk for those waiting for an appointment. All cases waiting longer than 15 weeks were flagged for review of risk and assessed for any change in circumstances.

Staff took active steps to engage with young people who found it difficult or were reluctant to engage with mental health services. Staff contacted other services to ask if they had other useful methods of engagement. Staff liaised with schools, GPs or other services to help ensure the wellbeing of children and young people.

Staff took a proactive approach to monitoring and re-engaging with young people who did not attend appointments. Staff would make two telephone call attempts, review risks, and close the case with a letter sent back to either the GP or the referring agency.

Staff in Shropshire reported that at times they found it difficult to offer flexibility in the times of appointments due to the limited number of rooms available. Two young people told us they did not like going to the base in Telford as they were seen within a school site. Staff at this base had options to meet young people at a local family centre or GP practice. Staff within the eating disorders team often met young people at home.

Teams tried to make follow-up contact with people who did not attend appointments, staff would text the young people prior to their appointments to remind them and as a way of improving communication.

Young people, parents and staff told us when they had their appointments cancelled they were offered another appointment as soon as possible. Appointments in Shropshire were mainly cancelled due to room availability.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘referral to treatment’. No targets were provided.

Name of hospital site or location	Name of team	Service type	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
Coral House Shrewsbury	0-25 Access and Brief Intervention	Part of the 0-25 Shropshire Service	N/A	12	N/A	11
Coral House Shrewsbury	0-25 ADHD	Part of the 0-25 Shropshire Service	N/A	60.5	N/A	137
Coral House Shrewsbury	0-25 ASD Assessment	Part of the 0-25 Shropshire Service	N/A	226	N/A	235

Name of hospital site or location	Name of team	Service type	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
Coral House Shrewsbury	0-25 CAMHS 0-5	Part of the 0-25 Shropshire Service	N/A	97	N/A	102
Coral House Shrewsbury	0-25 Complex Care	Part of the 0-25 Shropshire Service	N/A	66	N/A	77
Coral House Shrewsbury	0-25 Core Mental Health Team	Part of the 0-25 Shropshire Service	N/A	147.5	N/A	174
Coral House Shrewsbury	0–25 Crisis and Home Treatment Team	Part of the 0-25 Shropshire Service	N/A	4	N/A	10
Coral House Shrewsbury	0-25 Eating Disorders	Part of the 0-25 Shropshire Service	N/A	18	N/A	21
Coral House Shrewsbury	0-25 Learning Disabilities	Part of the 0-25 Shropshire Service	N/A	65	N/A	85
Coral House Shrewsbury	0-25 Looked After Children	Part of the 0-25 Shropshire Service	N/A	15	N/A	49
Coral House Shrewsbury	0-25 Youth Justice Service	Part of the 0-25 Shropshire Service	N/A	25	N/A	41
Crooked Bridge Road, Stafford	CAMHS Early Years' Service	We provide early, effective support for pre-school children who exhibit emotional and/or behaviour problems, where intervention by other services is not thought to be sufficient to meet their needs.	N/A	37	N/A	40
Argyle Street Clinic	CAMHS East	Provide a range of services to children and young people, aged 0-18, with persistent or severe emotional and behavioural mental health difficulties.	N/A	35	N/A	36
St Michael's Court, Lichfield	CAMHS Intensive Outreach Service	The CAMHS Intensive Outreach Team works alongside CAMHS Tier 3 services across South Staffs in a planned care way that is responsive to the fluctuations in the young person's mental health and risk management.	N/A	9	N/A	9
The Bridge Crooked Bridge Road Stafford	CAMHS West	Provide a range of services to children and young people, aged 0-18, with persistent or severe emotional and behavioural mental health difficulties.	N/A	41	N/A	44
161 Eccleshall Road, Stafford	CP SUSTAIN	We work with children and young people who are in care or adopted. We support foster carers and adoptive parents	N/A	31	N/A	31

Facilities that promote comfort, dignity and privacy

Most sites had suitable waiting areas for patients with sufficient chairs, toys for children and a variety of appropriate information about mental health services. However, in Staffordshire, the waiting area at Tamworth was small and cramped with very few sitting spaces.

The services had comfortable rooms to support care and treatment however in Shropshire staff reported that it was difficult to get rooms for appointments in bases at Shrewsbury and Telford and Wrekin. We saw an example whilst on inspection at Shrewsbury where staff had to reschedule and cancel four appointments due to lack of rooms available to use. Staff told us they were unable to offer patients forward appointments due to room availability. A staff member told us they could only offer appointments one day a week due to the rooms being unavailable.

Carers and staff told us that parking facilities at Shrewsbury were very limited and at times it meant that some young people and carers would miss their appointment whilst attempting to find suitable parking spot.

Interview rooms had an indicator on the door to show they were in use. Most staff offices and consultation rooms had inadequate sound proofing, having an impact on confidentiality. Conversations could be heard, we observed this during the inspection. Staff told us at times, this made dealing with sensitive confidential issues difficult for managers. Staff gave examples where at times this was distressing in sessions for anxious patients when they could hear distressed patients in the next room. In Telford and Wrekin, the base was situated underneath a public gym. Staff told us this was problematic as noise from the gym equipment could be heard during the day. Senior managers told us there were imminent plans to move to suitable sites in the near future.

Patients' engagement with the wider community

When appropriate staff ensured that patients had access to education and work opportunities. We saw evidence of staff working in partnership with schools and colleges in the care records we reviewed and our observations.

Staff supported patients to maintain contact with their families and carers.

Young people were encouraged to develop and maintain relationships with people that mattered to them within the wider community. Staff gave examples of joint meetings with Special Needs Coordinator and the school nursing team.

Meeting the needs of all people who use the service

Premises in Shropshire were accessible for people requiring disabled access. In Staffordshire where lifts were not available staff planned appointments for disabled patients and would ensure a ground floor clinic room was booked. In Tamworth, the waiting area was small, and the corridors cramped and did not have adequate space for wheelchair users to use comfortably. Additionally, the reception window was at standing height and would make access by a wheelchair user difficult.

Staff ensured information provided in waiting rooms was age appropriate to children and young people. We saw leaflets about the services provided within the different clinical pathway teams in the trust, local services, treatment, therapies offered, CQC ratings and how to make a complaint. Information leaflets in waiting rooms were in an easy to read format. We did not see leaflets in any language other than in English. Managers told us that leaflets in alternative languages could be provided by the trust.

Staff ensured children and young people had access to trust interpreters and signers when required.

Listening to and learning from concerns and complaints

This service received 15 complaints between 1 October 2017 and 30 September 2018. Three were fully upheld, five partially upheld and four not upheld. Two are still under investigation and one was withdrawn.

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
0-25 Wellbeing Shropshire, Telford and Wrekin	10	2	4	3	0	0	0	0
0-25 CAMHS Telford and Wrekin	2	1	1	0	0	0	0	0
CAMHS – East	2	0	0	1	0	0	1	0
CAMHS – West (Incl Stafford)	1	0	0	0	0	1	0	0
Total	**15**	**3**	**5**	**4**	**0**	**2**	**1**	**0**

This service received 47 compliments during the last 12 months from 1 October 2017 to 30 September 2018 which accounted for 0.4% of all compliments received by the trust (10971).

Carers and young people we spoke to knew how to raise a complaint and would feel comfortable making a complaint if needed. Information about raising complaints was available in the waiting areas.

Managers explained most complaints and compliments were managed in an informal way by the clinician or themselves. Staff supported people who wanted to make a complaint to the service.

Staff in Staffordshire gave examples of feedback they had received because of a complaint including lessons learned.

Is the service well-led?

Leadership

The services had managers and clinical leads at all levels with the right skills, knowledge and experience to run a service providing high-quality sustainable care.

Leaders had a good understanding of the services they managed. The service managers in Staffordshire and Shropshire had positive plans in place to align and drive the services forward and were only in the infancy stages of making the differences. They could explain clearly how the teams were working to provide high quality care. Leaders had worked across different services so

had a good understanding of their teams. However, staff felt that there was poor communication between their own teams in Shropshire, and senior managers were making robust changes without meeting or understanding them. Staff said there was a disconnect between the services in Shropshire and Staffordshire.

Leaders were visible in the service and approachable for the young people and staff. Staff described good working relationships with their local managers and said they were supportive and quick to respond. However, in Staffordshire, there was concerns raised about lack of communication between two managers. Staff gave examples of having to approach both deputy managers separately to action work related issues, leading to duplication of effort and occasionally conflicting advice.

Team leaders had access to leadership development training. Other staff within the teams had access to leadership training as part of their ongoing professional development plans. We saw examples where staff had been promoted into leadership roles or had been promoted within their professional roles, two staff members had completed the Improving Access to Psychological Therapies (IAPT) training to become service leads.

In Shropshire managers met commissioners fortnightly to give updates, discuss issues and agree action plans on the service recovery plan developed jointly with NHS Improvement.

Vision and strategy

Staff knew and understood the trust's vision and values, and how they applied to their work.

There were mixed views on whether senior leadership team had successfully communicated the trust's vision and values to the frontline staff in this service. The senior leaders were clear about the future service they wanted to build, however some staff felt they were not fully communicated to about some changes.

Staff told us they had not been given the opportunity to contribute to strategy and design for their services. However, in Shropshire senior managers told us they had held two development days in January 2019 to inform and discuss with staff the service changes. Staff could explain how they were working to deliver high quality care. There was a commitment to focusing on improving the quality and sustainability of care and young peoples' experiences through delivering best practice. However, there had been financial pressures on services within Shropshire mainly due to supplementary staffing of locums. Managers told us they moved moneys around to create extra posts although this still left the attention deficit hyperactivity disorder (ADHD) team with no staff and no vacancies to fill the posts.

Culture

Staff across the core service told us services were not aligned within the trust, they felt a disconnect and there were differences in working between Staffordshire and Shropshire. At the integration of Shropshire service into South Staffordshire and Shropshire NHS Foundation Trust in May 2017 they were part of the Specialist and Family Directorate. In June 2018 on the formation of the new trust, Midlands Partnership Foundation NHS Trust, care groups were established. In October 2018, due to a change of leadership within the Children's and Family care group, Shropshire services joined the Shropshire care group. Staffordshire CAMHS is part of the Children's and Family care group.Most staff we spoke with at Shropshire did not feel respected, supported and valued within the trust however, within their local teams, staff felt positive, passionate and proud about their work. Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle blowing process. They felt confident to do so when required. Most staff within Staffordshire did not know about the role of the Freedom to Speak Up Guardian and how to contact them if needed.

Managers told us they dealt with any interpersonal difficulties on a one to one basis when they occurred and during supervision. 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, 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 trust promoted equality and diversity through the inclusion work streams in its day-to-day work and in providing opportunities for career progression. The trust had sub groups of equality and diversity that represented different protected characteristics to ensure their views were equally represented.

The service's staff sickness and absence rate of 4.5% was slightly lower than the average for the trust 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 trust recognised staff success within the service this included an awards system to recognise staff and team achievements. Outreach staff had been nominated for a trust values award for listening and compassion. The medical director had nominated the East CAMHS service for the Royal College of Psychiatrist team of the Year.

Governance

The service managers had governance processes to manage quality and safety. However, at team level, managers did not demonstrate that governance processes operated effectively. For example, during the inspection local managers and clinical leads did not have oversight on how many children and young people were waiting for autistic spectrum disorder (ASD) and ADHD assessments. Staff we spoke with expressed uncertainty around the data quality of reports run via the system. Examples were given of waiting times being inaccurate and to mitigate this the service was compiling its own data to give a more accurate overview. There was inability to provide accurate data due to data cleansing. We were told that this had been raised as a concern to service leaders and flagged on their risk register. We were concerned that the trust could not provide us with accurate data. Due to concerns about service delivery and effective monitoring of outcomes the service in Shropshire was working closely with local commissioners and NHS Improvement to address these problems. There was a recovery plan in place that addressed clinical issues and the shortfalls in information systems within the service.

Each team had a meeting to which all staff were invited. The teams had their own agendas listed. The service manager told us she had recently introduced a team meeting proforma in line with CQC five key lines of enquiries, that was to be implemented in team meetings to offer consistency within the service. Staff we spoke with said they found the team meetings open, inclusive and effective. Minutes were produced from each meeting to ensure that staff who were unable to attend were updated.

There appeared to be no clear oversight of the environmental risk assessments. Local managers were not sure who had completed the environmental risk assessments. This meant they had no oversight of the environmental risks and staff were not aware of risks within their own buildings and areas patients were accessing.

There was limited evidence to suggest staff had opportunities to learn from incidents, complaints and service user feedback. Not all staff participated in clinical audits within Shropshire, for example staff were unaware that senior managers had carried out a health records audit in

January 2019. In Staffordshire staff gave examples where the audits were used to provide assurance and staff acted on the results when needed.

Staff worked closely with other organisations such as schools, public health, local authority and independent sector to ensure that there was an integrated local system that met the needs of young people living in the area.

There was inconsistency in the recording of supervision documentation and rates across the core service. The trust was unable to track supervision data. However, we were assured that supervision was taking place as staff reported that it was, and we saw evidence of documentation to prove it was taking place.

There were record-keeping omissions and documentation was poor, some risk assessments not updated, some care plans not holistic and failing to capture the care provided, however, there was no evidence of the quality of care being compromised. Feedback from young people and their carers was positive and we met genuine dedicated staff who were committed to providing a high standard of care, despite these pressures.

The overall compliance for mandatory and statutory training courses was 77%. This fell below trust target of 90%.

Management of risk, issues and performance

Individual teams kept local risk registers. Senior managers met and discussed risks at the monthly business meetings. 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.

Staff made notifications to external bodies as needed. There were records of safeguarding to local authority.

Buildings in Burton were in the process of being refurbished and we saw that the service had taken measures to reduce the impact on patients.

Information management

The services in Shropshire had recently changed from paper notes to an electronic notes system. This had caused some issues regarding timely accessing of previous notes as the notes had not been scanned into the system in any chronological manner.

Staff were issued with laptops and could work from any point with internet connection. At most the information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, in Staffordshire the shared offices were cramped at Lichfield and Burton and there was a limited number of laptops docking stations and telephones which staff reported as an issue. Not all staff had access to the equipment and information technology needed to do their work. Some staff had given their personal phone numbers to professional acquaintances to ensure they were contactable.

Staff found the trust's intranet very useful for providing information on development within the trust and access to policies.

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

Trust systems were not able to capture supervision rates across the core service. Services in Shropshire did not appear to have effective systems and processes in place to assess, monitor and improve clinical records, recorded documentation did not appear to reflect the care given for example documentation in processes undertaken within diagnosis of autism.

Staff raised a concern that they were no longer able to colour copy and that as a CAMHS service the ability to print in colour was significant to providing child friendly information and resources.

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

Engagement

Managers had an understanding of the challenges and priorities of the young people's needs. Their strategies and plans were fully aligned with commissioners and local stakeholders demonstrating a commitment to system wide collaboration. The trust had a website with support information and advice for young people and carers.

The trust provided newsletters, bulletins, emails and intranet information to keep staff up to date with information.

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 and friends and family tests on how patients and carers could give feedback to the service.

Not all staff were able to give examples of improvements made as a result of feedback from patients.

Service managers 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 told us they were formulating and embedding the thrive model of care with the ultimate aim of early prevention, resilience, improving care and support for children and young people.

Staff we spoke with said that development opportunities were plentiful, and several staff within Staffordshire had completed the Improving Access to Psychological Therapies accreditation. Staff were working to implement processes and policies to improve patient and carer participation and outcome measures.