Preparing for our CQC inspection

A guide for all staff
Introduction

This guide is designed to support you and your teams to feel confident and prepared for the forthcoming Care Quality Commission (CQC) comprehensive inspection commencing on Monday 12 September.

Following our last announced inspection in September 2015, we asked the CQC to come back to review our services and expected them to visit those services that didn’t get rated ‘good’ or ‘outstanding’.

However, having now completed all their first round of inspections, they’ve announced further planned inspections for this autumn and have decided to treat our visit as another planned comprehensive visit. It will be chaired by Beatrice Fraenkel, chair of Mersey Care NHS Foundation Trust.

We believe this gives us an early opportunity to improve on our overall rating of ‘requires improvement’ as we are now further on down our journey of improvement. It also gives our services a chance to improve on their previous ratings and all have set their own ambitions for their individual ratings.

The inspection will be carried out by a mixture of inspectors, healthcare professionals and experts by experience who will assess whether the service overall is: safe, effective, caring, responsive to people’s needs and well-led. More information on these five domains are within this guide.

Fundamentally, we need to remember that although we’ve been continually improving, we have excellent services with many examples of best practice and outstanding work and this is our chance to showcase our achievements.
Preparing for our CQC inspection

In April 2016, the CQC changed the way it inspects NHS services. This handbook will:

- Help you to understand the CQC’s approach
- Explain the five key questions the CQC will ask
- Suggest how best to prepare
- Provide you with contacts for further support and additional information
- Understand our strategic direction

Reading this handbook should not only assist in preparing you for a CQC inspection, but also offer best practice points for life beyond the CQC visit and business as usual.
Information about our Trust

Our strategic direction – our vision, values and quality priorities

Our vision
To be an outstanding organisation providing safe, personalised, accessible and recovery-focussed support / services every time.

Our values
Proud to CARE

Compassionate
Caring with compassion, it’s about how we listen, what we say, what we do

Approachable
Friendly, welcoming, sharing ideas and being open

Responsible
Taking personal and collective responsibility, being accountable for our actions

Excellent
Striving for the best, for high-quality safe care and continually improving

Our quality priorities
SPAR – safe, personalised, accessible, recovery-focussed.
Our Board

David Rogers  
*Chair*

Caroline Donovan  
*Chief Executive*

Tony Gadsby  
*Non-Executive Director*

Maria Nelligan  
*Director of Nursing and Quality*

Bridget Johnson  
*Non-Executive Director*

Suzanne Robinson  
*Director of Finance and Performance*

Patrick Sullivan  
*Non-Executive Director*

Tom Thornber  
*Director of Strategy and Development*

Dr Buki Adeyemo  
*Medical Director*

Paul Draycott  
*Director of Leadership and Workforce (non-voting)*

Andy Rogers  
*Director of Operations (non-voting)*

We currently have two vacancies for non-executive director posts. We anticipate that appointments will be made by early autumn 2016.
Our approach

Supporting people to live well

The people who use our services expect us to:

- Put their needs first at all times
- Be **aware** and **take ownership** - if you know of or notice any issues, address these as soon as possible by raising them with your line manager or through the appropriate processes
- Be **honest, polite, helpful** and **welcoming** - answer any questions you can to the best of your ability and if you aren’t sure ask a colleague for help
- Be **proud** and **positive** - celebrate the excellent work you do by talking about how your service makes a real difference
- Be **prompt** and **responsive** - if an issue is raised, rectify it as soon as you can or, where this isn’t possible, log it and report it to your line manager
- Be **inclusive** - it is really important that anyone in contact with or working in our services has the opportunity to engage with the CQC and talk to them during their visit.

CQC inspections are our opportunity to:

- Showcase our good work, our strengths and achievements and the improvements we have made
- Demonstrate that we know where our improvement areas are and what we are doing about them
- Demonstrate how we gain feedback about the care we provide, how we learn and share lessons to make changes for the better for the people who use our services.

We know that our services aren’t always perfect. We need to be able to tell the story of what we are doing well, where we are making improvements and where our services are aiming to be.
On **Monday 12 September 2016**, the Care Quality Commission (CQC) will be sending around 70 inspectors to North Staffordshire to review all of our services. The inspectors will operate in small teams over five days that week. The teams will inspect all inpatient areas and a sample of community-based services across directorates - these will be determined by the inspectors during the week.

The inspectors will represent a wide variety of disciplines and specialities. They will be well-informed and briefed in detail about our services. We have provided a lot of information to the CQC to help them assess our services.

The CQC inspectors will visit our teams and talk to many of our staff - managers, clinicians, medics, administrators, reception staff, domestic services, catering staff, management and corporate staff. They will **observe care and talk to people receiving care** as well as their carers and family members. They will review clinical records and corporate information.

Feedback cards/comments boxes will have been distributed around the Trust and they will host focus groups with staff, people using our services, carers, family members and other stakeholders to gather a wide range of feedback.
What are our star qualities?

**Safe**
- Robust safeguarding processes
- Keeping service users and staff safe from harm
- Risk aware
- All staff up to date with training
- Safe staffing levels

**Well-led**
- Clear, effective clinical leadership in the team
- Structure for supervision and reflective practice
- Clear and well known governance structures
- Staff fully aware of personal roles and responsibilities
- Working with partners to improve services

**Effective**
- Cohesive, supportive team
- Effective clinical supervision
- Outcome measures used
- Joint working with Multidisciplinary Team (MDT)
- Timely intervention
- Evidence-based practice

**Responsive**
- Service responsive to clinical need
- Timely access to assessment, treatment and review
- Flexible response to fluctuating referral levels
- Listening and responding to feedback
- Responsive to changing needs

**Caring**
- Service users and family centered
- Involving service users, carers and family members in care planning and decisions
- The ward, clinic looks caring
- Caring with compassion
- It's about how we listen, what we say, what we do
**The five key questions**

The CQC will focus their inspection around five questions about the quality of our services based on what matters most to people. When telling your story always have these five questions in mind:

**Is it safe?**

People are protected from abuse and avoidable harm.

**Is it effective?**

People’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

**Is it caring?**

Staff involve and treat people with compassion, kindness, dignity and respect.

**Is it responsive?**

Services are organised so they meet people’s needs.

**Is it well-led?**

The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

To understand these five key questions further and for practical prompts in preparation, see Appendix A.

In the weeks after the inspection, the CQC may visit sites unannounced.

Once satisfied, they will write a report based on their findings and will rate the Trust and its services as ‘Outstanding’, ‘Good’, ‘Requires Improvement’ or ‘Inadequate’.
How best can I prepare?

There is a lot you can do to ensure you are prepared for the CQC’s visit. These are things you already do and know.

- **Keep informed:** Please attend our staff briefing sessions (dates are in Appendix C), engage in supportive preparation activities, talk to your team/manager. Please read the CEO Blog, our weekly CQC newsletter, the SID CQC Information page (information here can be printed out for your CQC folders), Team Brief and News Round. You can also talk to your team/manager.
- **Review Appendix A:** This will give you a good overview of the five key questions and useful prompts for you to consider personally and as a team.
- **Share best practice and learning with colleagues:** Be proactive in sharing approaches that could benefit other areas.
- **Practice telling your service’s achievements and ‘story’:** Be clear, open and honest about what you do, focusing on what you do at present and plans for the future.
- **Read our themes of the week that have appeared in our CQC newsletters, see Appendix D.**

**General housekeeping for everyone, all the time:**

**Please:**

- Wear your name badge at all times
- Review notice boards and speak to Jacqui Wilshaw, Head of Patient and Organisational Safety, who’s working on new standard posters for all areas. All new posters will need to be reviewed by the communications team. Check information leaflet stands are still current and stocked - the CQC may ask you about information that is displayed
- Ensure alcohol foam is available and use it on entering premises and inpatient units (we have changed from alcohol gel to foam and added more dispensers) and ensure all staff are wearing alcohol gel tottles. Inspectors will be given alcohol gel tottles when they arrive. There will also be extra alcohol gel tottles available in inpatient units during the inspection week should you need them
- Make sure all areas including offices/receptions are clean and tidy
- Make sure your email inboxes are clear enough to allow for information flow during the visit
- Make sure your appraisal and mandatory training is 100% up to date including safeguarding training
- Replace broken furniture or remove items no longer used
- Ensure all new staff have good inductions
- Know how to find Trust policies and be aware of the content of those pertinent to your role. Policy, practice, training and issue summaries (PPTI) are on the CQC information page on SID
- Make sure the outside environment is safe, welcoming, clean and tidy, including any gardens, courtyards or pathways
- Ensure your clinical records are up to date, including all care plans, risk assessments and crisis/contingency plans - person-centred care planning and risk assessments must be completed for every service user
- Know how you would raise a concern, for example a safeguarding issue and how you would contact our Freedom to Speak Up Guardian if you needed to
- Recognise and discuss as a team your service strengths and less strong areas and know what is being done to make improvements
- Know how lessons are shared and learned in your team, for example from complaints and incidents.
During an inspection

The inspection team will divide into smaller groups for their visits.

They will want to talk to a wide range of people who use services, carers and family members, and staff (at all levels) about their experiences of care, and will also observe everyday activities and the environment.

They may visit during the day or night and will want to review a selection of people’s clinical records to check they are accurate and up to date. They will assess if systems and processes operate as laid out in policy, and follow the patient pathway through the service.

When the CQC arrive, please:

- Welcome the inspecting team and ask to see their identification badges. Do not allow anyone access without the proper authorisation/ identification
  
  If in any doubt, contact the CQC project office on 01782 652104 (ext 8422) between 8.30am-5pm

- Sign them in and ensure the most senior member of your team is called to meet and accompany the inspecting team, to introduce them to the service area and facilitate their visit. Orientation to the area should include safety and facilities

Having welcomed the inspectors, ask a colleague to:

- Notify the Trust CQC project team of their arrival at your team by contacting:

  Contact the CQC project team on 01782 652104 (ext 8422) between 8.30am-5pm.

  Out of hours contact the duty senior nurse and email the CQC project team at CQCquality@northstaffs.nhs.uk or contact the team early morning by phone.

Engaging with the inspection team:

- Remember, patient care comes first – the inspectors will know this. If you are busy, let the inspector know that you will be with him/her as soon as you are free and give a specific time wherever possible. Try to keep disruption to the service to a minimum

- Inspectors should not take away any clinical notes (or photocopies)

- Inspectors may request to see and review people’s clinical records on the Trust’s information systems (CHIPS). See ‘When an inspector wants to access clinical records’ on page 13. Please accompany them to do this and help them to navigate CHIPS.
When an inspector wants to talk to you:

- Be **open** and **honest**, and as helpful as you can.
- Be **proud** and **positive** and celebrate the **excellent** work you do by talking about how your service makes a **real difference** and meets people’s individual needs in partnership with them, their families and carers.
- Be mindful that you **keep conversations away from public areas** to avoid disruption or breaching confidentiality.
- **Encourage service user/carer participation** in the chat where appropriate/possible.
- Respect people’s privacy and dignity: **always check with people first** if the inspectors want to observe your interactions with them.
- Be mindful of where you **know improvements are needed and share how we are responding to these**. In preparing, make sure you know both your service’s achievements and where improvements are taking place before the visit, and have evidence to demonstrate these. If an issue is raised, outline our plans to improve in this area.
- If you don’t understand the question or don’t know the answer, **don’t panic** - ask for clarification or state where you will go for the information and get back to them.
- **Familiarise** yourself with where your team’s documentation is held e.g. staff rota, policies, procedures and protocols, information leaflets, close observation monitoring sheets, staff supervision recording systems, mandatory training, environmental risk assessments, business continuity plans, health and safety risk assessments, risk registers etc.
- **Familiarise** yourself with Trust systems and, if you are uncertain about where to find information, ask one of the CQC project team (**see back page**).
- **Act promptly**: Any local information that is requested should be provided via the team manager. The team manager should **keep a log of all items requested** and provide to the CQC.
- If the information requested is of a corporate nature, or for further support, contact:
  - your line manager
  - service manager/Modern Matron
  - the CQC project team on 01782 652104 (ext 8422)
  - or email CQCquality@northstaffs.nhs.uk

When an inspector wants to access clinical records:

- During the visit, the inspectors will review clinical notes. They are allowed to ‘**view only**’ and no clinical information can be taken away with them.
- Inspectors are allowed to access clinical notes via your staff log-in and **access is to be strictly supervised at all times**. Ask to see their ID prior to logging in and always lock your screen if you get called away.
- When entering a record specify ‘**Audit/Investigation**’ for the reason, and make an entry that the notes have been reviewed by the CQC.
If the inspecting team identify an issue:

- We need to act **promptly** and **responsively**
- Where issues are raised, these need to be **logged** by the team manager on **Safeguard** and escalated
- Issues should be rectified before the inspection team leave, or where possible before the inspection week is complete. Where this isn’t possible, actions need to be put in place
- Issues raised need to be fed back by the team manager to the Team Leader, Ward Manager, service manager, Modern Matron, Head of Directorate and also emailed to the CQC project team on **CQCquality@northstaffs.nhs.uk** directly after the visit.

After the inspection

**Immediate:**

- Where possible, have a **team brief** and pull all the key messages together, issues raised and documentation provided
- **On the same day**, the team manager has the responsibility of forwarding this information to the Head of Directorate and to the CQC project team on 01782 652104 (ext 8422) or by email: **CQCquality@northstaffs.nhs.uk**
- Feeding back will directly inform our daily update messages to all services, and will help support those still expecting a possible visit
- The CQC will then decide on **ratings** for each of our services as well as the Trust as a whole. The rating will be one of the following:
  - **Outstanding**
  - **Good**
  - **Requires Improvement**
  - **Inadequate**
- We will receive a final inspection report for a ‘**factual accuracy check**’ before the final version is published
- **Our ratings will be published** on the CQC’s website. We will also be required to **display our ratings** at each of our registered sites.

**Later:**

- Once the CQC has finished their visit they will analyse the information they have been provided, messages they have heard and what they have observed. This may **prompt further unannounced inspections** in the weeks after the comprehensive inspection
- It is always important to remember that although the CQC receives regular updates on any action plans we are delivering, they **can return to visit us at any time** to assess progress or services for themselves.
Don’t worry!

In the coming weeks, prepare as far as you can by:

- **Reviewing the prompts within this guide** which give you a good idea of what the inspectors will look out for and what you might be asked about. The CQC’s key lines of enquiry represent business as usual and the things you will already be doing as part of delivering your service

- **Talk to your team and line manager** for support. If you still feel anxious, contact the CQC project team for further information

- **Read updates via the CQC newsletter, SID CQC Information page, Team Brief, News Round, and the CEO Blog**, as well as posters in staff areas. These will all contain timely and useful updates

- **Book onto one of the staff briefing sessions**, details are on SID.

- For further specific support in place at all times see the ‘*contact details*’ on the back page.

For further reading and more detailed information:

- See Appendix A

- Review the CQC Specialist Mental Health Provider Handbook and supporting appendices:
Appendix A

The CQC’s key focus is good people care.

Ask ‘Is my service Safe, Effective, Caring, Responsive, and Well-led?’

The following provides you with additional practical prompts to consider within each of these five key questions. They are not exhaustive; add to them and follow up with your team or manager for where you feel improvements are needed, or for more information.

Safe

People are protected from abuse and avoidable harm

- Is safety my main concern?
- Are people kept safe in my team/on my ward because we maintain the correct staffing levels, do we have bank staff and have effective handovers?
- Where bank staff are used, have they had a good induction and are they properly trained?
- Have I been trained in safeguarding specific to the area I work in (e.g. older people, children or adult services)?
- Do I know how to report an incident, near miss or allegation of abuse/safeguarding issue? Do I act promptly and are concerns addressed in a timely way?
- Do I make sure the clinical environment is safe before seeing a person?
- Are medical devices I use well maintained before use? Are they decontaminated before and after use? Am I trained and competent to use them?
- Do I know where to locate resuscitation equipment?
- Do I know how to obtain advice on medicines?
- Do I know the procedures for controlled drugs and safe handling/securing of drugs?
- Do I always check a person’s allergy status and note this?
- Do I know what do if a person has an adverse reaction or if their health deteriorates? Do I know what to do in an emergency?
- Do I always follow the hand hygiene procedures before and after touching a person?
- Do I know who to contact for advice on infection control?
- Have I had my flu jab?
- Do I continually risk assess and monitor my people (for both physical and mental health), ensure notes, care plans and alerts are updated accordingly and act promptly to changes?
- Have I been trained in physical assessment intervention? Do I report incidents and update the MDT notes and have a staff debrief?
- Do I know how to raise day-to-day concerns or make a complaint or whistleblow internally?
- Is data from audit reports, safety incidents and person feedback (complaints, survey etc.) discussed at our local team meetings, with lessons shared with colleagues and improvement actions decided and acted upon?
- Do I know what my team’s risk register says?
Effective

*People’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on best available evidence*

- Am I aware of NICE guidance relevant to my work; do I follow it?
- Do I get involved in clinical audits and can I show resulting improvements?
- Do I assess the person holistically and is this reflected in care/treatment plans which are regularly reviewed?
- Do I undertake the necessary risk assessments, keep them current and reflect them in care/treatment plans?
- Do I involve people to design their own care/treatment plan and offer them a copy? Is the care plan recovery-focussed?
- Do I involve and support carers to be able to care for their loved one?
- Do I ensure multidisciplinary involvement in people’s care and participate in handover and multidisciplinary meetings?
- Do I ensure people who are approaching end-of-life are identified and care delivered according to their care plan?
- Are people supported with smoking cessation?
- Do I ensure people’s nutrition and hydration are met?
- Do I support pain management in a timely way?
- Do I maintain my personal knowledge by attending training/conferences or reading guidance and journals?
- Do I attend regular meaningful clinical supervision (group or individual) and feel supported in personal development?
- Have all my competencies been assessed and signed-off this year?
- Do I understand and follow the correct recruitment procedures?

Caring

*Staff involve and treat people with compassion, kindness, dignity and respect*

- Do I always introduce myself and wear my NHS ID badge at all times?
- Do I always give my service’s contact details to people/carers, and where to get support out-of-hours?
- Do I always treat people/carers with dignity, respect and kindness and provide privacy and confidentiality at all times?
- Do I report any disrespectful, discriminatory or abusive behaviour towards people?
- Do I give people/carers information about the services available to them, about their treatment or medication, and where to gain further support?
- Do I promote self-management, independence and recovery?
- Do I always consider the person’s personal, cultural and/or religious needs?
- Are notice boards and information leaflets up-to-date and stocked?
- Do I always involve people/carers in decisions about their care or treatment and take a personalised, co-productive approach?
- Do I understand discrimination, diversity and inclusion?
- Do people/carers know how to make a complaint/compliment?
- Is the environment clean and comfortable?
Responsive

*Services are organised so that they meet people’s needs*

- Do I always take a personalised approach to care?
- Do I prioritise people according to their need?
- Do I make appropriate arrangements to support special needs?
- Do I know how to contact an advocate or interpreter for the person?
- Do I gain the appropriate consent before proceeding?
- Do I provide the information (benefits/risks) to gain valid consent? Do I know how to document consent?
- Am I able to test for capacity (under the Mental Capacity Act) and do I understand DoLS (Deprivation of Liberty Safeguards)?
- If a person lacks capacity, do I know how to ensure their best interests are assessed and recorded?
- Are people’s waiting times kept to a minimum and are these managed?
- If I cancel an appointment, do I give an explanation and provide a follow-up?
- Do I ensure people are seen as close to their home as possible?
- Are people kept in hospital for the minimum amount of time needed?
- Are call bells answered promptly?
- Are inpatients able to go outside and not prevented for long periods from doing so?

- Do I encourage people to feedback their experiences of the service and provide means to do this e.g. the Friends and Family Test
- Do I know what people are feeding back about the service, and do I act on person/carer feedback? Do I know what improvements are being made?
- Are people informed about how to make a complaint/compliment? Are complaints dealt with within timescale?
- Does the team share lessons and learn from clinical audits, incidents or complaints/compliments? Can I think of some examples?
- Am I aware of our Board to ward visits and do I know the outcome and issues raised? Do I know what actions have resulted?
- Am I aware of any previous CQC inspections to my service? Do I know the issues raised and what actions are in place and progress? And how the team manages its compliance against CQC standards and outcomes?
Well-led

The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture

- Did I have a corporate and local induction when I started work here?
- Do I know the Trust’s direction - its vision, values and quality priorities?
- Have I had my appraisal and ongoing supervision with my manager?
- Do I have a personal development plan?
- Is my mandatory and statutory training up-to-date?

- Do I have access to reflective practice groups (where relevant)?
- Do I attend team meetings, staff listening events and away days?
- Do I know how to complain, whistleblow or raise a safeguarding alert?
- Do I know how to find support in HR, occupational health or a union?
- Do I know what the current risks are for my team or service? Are lessons shared and learned from incidents/ complaints/ audit/person feedback? Do I know what actions are in place?
Appendix B

Frequently asked questions

• Will the inspectors provide an agenda for their meeting with me? Do they have a list of set questions that they ask everyone that they meet?

It is unlikely that inspectors will provide agendas for their meetings with members of individual staff. The specific questions that inspectors may ask are likely to depend on the issues that they are particularly interested in knowing about, at that point in the inspection process. There is information available on the CQC website (www.cqc.org.uk) about the ‘key lines of enquiry’ if you want to prepare in advance.

• Is it possible to find out more about the background of the individual inspectors?

Let individual inspectors introduce themselves to you as they want. Most inspectors are people with current or recent active roles working in other mental health and learning disability services. Their specific backgrounds are probably not particularly relevant to their role as CQC inspectors.

• What should I do if a service user or carer needs something when I’m talking to an inspector?

Our priority at all times is the delivery of excellent care. You should always prioritise and respond to people’s needs including while inspectors are on site. Inspectors will understand this if you explain.

• Can I send pre-read information to the inspectors in advance of the inspection? Can I offer inspectors further written information about the service that my team provides during their visit?

The CQC have already requested quite a lot of information in advance of the inspection visit, and will ask for anything specific that they require. It is not possible to send any additional pre-read information to individual inspectors in advance of the inspection visit, but you should share anything that you feel is important during the visit itself. Just ask inspectors what further written information they would like.

• Will the inspectors want to talk to just the team manager or to other staff as well?

Inspectors will want to talk to various members of the team, including managers but also other team members from different disciplines. Introduce the inspectors to the team and ask who it is that they would like to talk to.

• Is it OK for inspectors to talk to service users and carers?

We want to encourage people who use our services and carers to engage with inspectors as much as they want to. In some settings, including inpatient areas, easy read information could be provided about the inspection and patients and carers could be informed that inspectors may be visiting.

• Why is the inspection team so large? Why do they need so many inspectors?

A large team is needed to cover all the sites and services we provide and to ensure that the team includes specific areas of expertise - for example, mental health legislation or medicines management.

• Should I provide refreshments for the inspectors?

The offer of a hot drink or a glass of water is often appreciated by any visitor. There is no need to organise any further catering.
## Appendix C

### Staff briefing sessions August/September

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Time</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday 31 August</td>
<td>Unit 1, Dragon Square, Seminar Room</td>
<td>1.30pm-2.30pm</td>
<td>Laurie Wrench, Zoe Grant</td>
</tr>
<tr>
<td>Wednesday 31 August</td>
<td>Unit 1, Dragon Square, Seminar Room</td>
<td>2.45pm-3.45pm</td>
<td>Laurie Wrench, Zoe Grant</td>
</tr>
<tr>
<td>Thursday 1 September</td>
<td>Harplands, Academic Rooms 1&amp;2</td>
<td>10.30am-11.30am</td>
<td>Maria Nelligan, Laurie Wrench, Zoe Grant</td>
</tr>
<tr>
<td>Thursday 1 September</td>
<td>Harplands, Academic Rooms 1&amp;2</td>
<td>11.45am-12.45pm</td>
<td>Maria Nelligan, Laurie Wrench, Zoe Grant</td>
</tr>
<tr>
<td>Wednesday 7 September</td>
<td>Lawton House, Boardroom</td>
<td>9am-10am</td>
<td>Laurie Wrench, Zoe Grant</td>
</tr>
<tr>
<td>Wednesday 7 September</td>
<td>Lawton House, Boardroom</td>
<td>10.15am-11.15am</td>
<td>Laurie Wrench, Zoe Grant</td>
</tr>
</tbody>
</table>

You will need to book for a session via Eventbrite. The links to each session can be found on the front page of SID.
Appendix D

Key themes:

Care planning & risk assessment

Regulation 9 of The Health and Social Care Act (2008) relates to person centred care. The intention of this regulation is to ensure that people who use a service have care or treatment that is personalised specifically for them and that this is based on assessment of needs and preferences.

What the CQC told us

- Not all service users had a care plan and risk assessment in place
- Care plans and risk assessments that were in place did not always involve the service user and or carers
- Care plans were not always recovery focused
- They did not identify service user strengths
- Care plans and risk assessments did not identify review dates and were not always reviewed in a timely manner.
- Service users’ views and opinions were not recorded in care plans or risk assessments
- Risk assessments were not standardised.

What have we done?

- Electronic systems are now in place to ensure that all care plans are available electronically in the CHIPS patient information system, meaning that all new service users have care plans directly inputted into the electronic system.
- There is now a standardised risk assessment tool within the CHIPS patient information system, meaning that all new service users have risk assessments directly inputted into the electronic system.
- All clinical teams are in the process of ensuring that all existing service users’ care plans and risk assessments are transferred over into the electronic systems.
- The care plan and risk assessment templates have been updated and now support a personalised and person centred approach to care planning and risk assessment.
- Care plan training is being delivered as a mandatory requirement and clinicians are reviewing all care plans and risk assessments with service users to ensure that they are suitably engaged in the effective care planning process and that person centred care principals are being applied.
- There is an effective care planning group in operation and chaired by the Executive Director of Nursing and Quality. The meeting runs monthly and membership consists of clinicians from all clinical directorates.
- A Trust-wide care plan and risk assessment audit has been developed and is completed on a monthly basis and any required improvements discussed with clinicians at their caseload management /management supervision session.
Standards in practice

• All service users within the Trust must have a care plan and risk assessment in place

• All care plans and risk assessments need to be entered into the CHIPS system.

• If you are unsure with which care plan template to use in CHIPS please ask your team manager.

The care plan templates are:

• CPA care plan

• Standard care plan

• Intervention plan

• Initial risk assessment and plan (only for assessment services)

• All care plans and risk assessments must be reviewed by the clinician responsible for the plan to ensure that they demonstrate the following key principles:

  o Service users are actively involved in their care plan and risk assessment (or a clear explanation given if not).

  o Carers are involved in an individual’s care plan where appropriate and attempts have been made to engage relevant carers in the risk assessment process.

  o Care plans and risk assessments clearly demonstrate what the service user’s views and opinions are (and where necessary the views of their carer’s).

  o Care plans clearly highlight an individual’s strengths and abilities, their future life and health ambitions and their expectations of the care being offered.

  o Care plans are developed with service users’ highlighting clear goals which are measurable and recovery focused, with discharge planning being considered.

  o Care plans need to reference the therapeutic interventions being delivered.

  o Care plans need to include how risks are managed, including staffing.

• Once an electronic care plan is in place, a copy is to be printed out and given to the service user (preferably immediately but if this cannot be achieved then either at the next appointment or via the post). A paper copy does not need to be retained.
Mental Health Law

Regulation 11 of The Health and Social Care Act (2008) relates to the need for consent. The intention of this regulation is to ensure that people who use a service and those acting on their behalf have given consent before any care or treatment is provided.

Regulation 13 of The Health and Social Care Act (2008) relates to safeguarding service users from abuse and improper treatment. The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

What the CQC told us

- Informal patients were not always aware of their rights to leave the ward
- Staff must ensure that appropriate legal authority is in place if they prevent informal patients from leaving the ward
- The Trust did not have a seclusion room meeting the Mental Health Act Code of Practice guidance
- Staff had limited understanding of the principals of the Mental Capacity Act and how they apply to young people aged 16-17 years
- Patient’s capacity and ability to consent to be involved in planning, management and review of their care and treatment was not routinely established
- Where applicable the Trust must ensure that capacity to consent has been assessed prior to treatment being given

What have we done?

- Electronic systems are now in place and ensure that consent and capacity has been established for every patient and visible within the CHIPS electronic patient record
- Information leaflets have been developed for informal patients explaining to them their rights when on the inpatient wards
- Information has been developed for staff, specifically around de-facto detention
- The signage in the inpatient areas has been improved to give clear guidance to informal patients of what to do should they wish to leave the ward
- The Trust has identified a designated seclusion room on ward 1 at Harplands Hospital. Work is underway to ensure that the room is fit for purpose and is expected to be complete by 31 August 2016
- Assurance has been obtained that all patients who are detained under a community treatment order are aware of their rights and this will be monitored regularly by clinicians. Training is also underway for all clinicians, which outlines clear guidance of how to apply and manage this element of the Mental Health Act
- The Mental Health Law governance group continues to meet on a bi-monthly basis and monitors quality improvements and assurances
- The Mental Health Act audit outcome reporting has been centralised to ensure the Trust has regular overview of quality compliance. Weekly reports are being produced for this
• Guidance has been reissued for all staff who come into contact with young people regarding the Gillick Framework and assessment of competence and which will be incorporated into the revised consent policy

Standards in practice
• Team leads to ensure that all staff are aware and adhere to Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) Codes of Practice
• Ensure that all staff have a working understanding of the statutory principals which underpin the Mental Capacity Act

Mental Capacity Act five key principles
The Act is underpinned by five principles, which are contained within the act and explained in the Mental Capacity Act Code of Practice:

1. A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise

2. The right for individuals to be supported to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make their own decisions

3. That individuals must retain the right to make what might be seen as eccentric or unwise decisions

4. Best interests – anything done for or on behalf of people without capacity must be in their best interests

5. Least restrictive intervention – anything done for or on behalf of people without capacity should be an option that is less restrictive of the person’s rights - as long as it is still in their best interests

• All clinicians to ensure that statutory documentation is properly completed
• All staff to ensure they understand what constitutes restrictive care and demonstrate that least restrictive options of care have been considered and clearly documented/care planned
• All clinicians to ensure they are consistently obtaining consent, assessing capacity, supporting decision-making and considering the best interests of service users and that this is documented in the notes on the appropriate paperwork
• All clinicians to ensure that patients have their rights regularly explained both in hospital and in the community in line with Section 132 and form L3 for detained patients and form L3a for informal patients are completed at each attempt whether successful or not
Environment

Regulation 15 of The Health and Social Care Act (2008) relates to premises and equipment. The intention of this regulation is to ensure the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and properly.

Regulation 12 of The Health and Social Care Act (2008) relates to safe care and treatment. The intention of this regulation is to prevent people from receiving unsafe care and treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. Safe premises and equipment and infection control measures are important factors within this regulation requirement.

What the CQC told us

- The Trust must ensure that appropriate warning notices are displayed where oxygen cylinders are stored
- Equipment provided in the community for the storage of medication must be properly maintained
- Premises used by the Trust must be suitable for the purpose of which they are being used
- The equipment being used for providing care or treatment to the service user was not safe for such use
- Weighing scales in the services had not been calibrated regularly
- Infection control audits were not undertaken
- Services were not assessing the risk of preventing, detecting and controlling the spread of infections

What have we done?

- Assurance was obtained that appropriate warning notices were displayed in all areas where oxygen was stored
- The equipment provided in the community was addressed and services had access to a fridge to store medication
- The Access Team moved to join the Home Treatment Team at Harplands Hospital due to concerns regarding the suitability of the service being located at the Hope Centre
- Improvement works have taken place at Dragon Square to ensure that sound proofing was improved, ligature risk addressed
- Marrow House staff have relocated in order for work to be completed to improve their waiting area.
- Equipment managers are in place in all teams and equipment work book guidance adhered to
- Toy cleaning regimes are in place in all services providing care for young persons
- Service areas have been visited by infection control leads within the Trust and also the Director of Nursing and Quality to ensure that standards are maintained
- There is a programme for infection prevention and control audits
Every clinical area needs to

• Check that you know who your team’s equipment manager is and where the equipment work book is located; know its content

• Ensure that you are familiar with the infection control policy and standards; compare them to your work environment and address concerns immediately

• Ensure that you are familiar with health and safety standards; are fire exits free and clear from clutter?

• Do you know how to operate and use equipment safely, ask for help and advice from your line manager if you are unsure?

• Always remember that the first impressions for service users and carers count, you don’t always get a second chance

• Always make sure that any new equipment purchased meets infection prevention and control standards and is fire retardant as well as meeting clinical needs

• Remember that any equipment must be able to withstand outbreak cleaning methods

• Always ensure the Infection Prevention Team are engaged any proposed room changes/building alterations

• Keep areas clean, tidy and always store items off the floor

• Clear out unwanted items, furniture and clutter. You and your team may want a ‘rapid clean-up day’, ask night staff to clean store rooms etc.

• Keep up to date clinical cleaning records. Always use the green “I’m clean” labels once an item has been cleaned

• Ensure all notice boards are neat and tidy and the information is relevant and in date

• Ensure that all condemned items are removed in a timely manner, don’t leave it to another person to remove

• Always report any faulty/defective equipment in a timely manner, label and remove out of service if appropriate

• Liaise with Support Services staff to ensure access can be gained to rooms to allow cleaning to take place

• Always put stores deliveries away in a timely manner

• Know the fire evacuation plan
Mandatory training and clinical supervision

Mandatory training

Mandatory training is compulsory training that is essential for the safe and efficient delivery of services. This type of training is designed to reduce organisational risks and comply with local or national policies and government guidelines.

The Trust delivers mandatory training as part of corporate and local induction for all staff (except doctors in training and specialist registrar trainees allocated through the regional training programme). A rolling programme of mandatory training sessions and refresher or update training is also provided within the Trust. Further information can be found on the mandatory training page on SID.

What the CQC told us

- A variety of mandatory training is available for staff – this included courses in managing actual and potential aggression (MAPA), safeguarding adults, health and safety and information governance
- There were good levels of completion for infection control mandatory training and regular Trust-wide cleanliness audits were undertaken

What you need to know

- Everyone’s requirements are detailed in the mandatory training matrix – this can be found via the mandatory training page on SID
- The majority of mandatory training is available via e-learning
- Face-to-face training is also available – did you know that 51% of places at training sessions are not filled either due to non-booking, withdrawal or by staff not attending?
- Please ensure you attend a training session that you have booked on to
- Understand and be aware of your responsibilities with regard to mandatory training
- Managers should ensure their team members are released to take part in training to ensure places are filled and that staff are fully compliant

What have we done?

- E-learning is widely available for all non-physical mandatory training
- Face-to-face sessions are available for all physical and non-physical mandatory training
- Staff are informed three months prior to becoming out-of-date to book on courses
- There is centralised co-ordination of mandatory training courses
- All staff receive a monthly training statement identifying their current status
- All managers receive their team’s mandatory training reports
- Face-to-face safeguarding training is available
Clinical supervision

Clinical supervision is a necessary tool which supports staff in the delivery of high quality, evidence-based and effective care.

Working with people with mental health, and other complex health problems requires high levels of inter-personal and clinical skills with a focus on growth and support, enabling us to develop and sustain high quality practice (Bond and Holland 1998).

As a Trust we believe that clinical supervision is an essential part of your reflective practice to enable you to deliver even better care and also a mechanism that supports staff resilience. Most professional groups have identified and specified minimum standards for clinical supervision. Guidance from the Nursing and Midwifery Council (NMC) states that mental health nurses should “actively promote and participate in clinical supervision and reflection, within a values-based mental health framework, to explore how their values, beliefs and emotions affect their leadership, management and practice”.

What the CQC told us

• The Trust should ensure that a record of supervision is maintained

What have we done?

• We have a comprehensive register of clinical supervisors

• Training is provided for all clinical supervisors

• An easy-to-use system of recording clinical supervision has been set up on SID – this can be found by following the link via the ‘quick links’ section on the front page of SID

• As of the end of July 2016, the Trust was at 79% compliance for clinical supervision

What you need to know

• Every clinical member of staff should receive clinical supervision a minimum of every two months (unless on maternity leave or sickness absence)

• All clinical supervision must be recorded in a timely fashion via the link on SID – it only takes a minute to complete

• Every team should be over 90% compliant when it comes to clinical supervision

• You should be aware of and read the Trust’s clinical supervision policy on the Policies page on SID - this provides lots of helpful support, including templates for recording outcomes etc
Regulation 18 of The Health and Social Care Act (2008) relates to staffing. The intention of this regulation is to make sure that the providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

To meet the regulation the providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out the responsibilities of their role. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practice.

What the CQC told us

• The Trust must provide sufficient and suitably qualified, competent, skilled and experienced people in order to meet the needs of patients and the Trust’s regulatory obligations

Information on the induction process

• The formal induction process includes a two-day corporate induction programme consisting of an understanding and familiarisation of the wider organisation, including an overview of the NHS and the care services we provide

• This includes a welcome to the Trust, our vision and quality standards, structure, strategic direction and objectives, as well as our values and an overview of the services we provide. Key issues are discussed, e.g. information security, fraud awareness, local security awareness, raising concerns and incident reporting and key policies, alongside where and how to access further information

• A key element of the day is our Trust marketplace, whereby new employees have the opportunity to meet with and learn about a range of in-house and partner agency services to support them in their roles, including staff side representatives, finance services and infection control colleagues

• The second day covers the key elements of mandatory training for all staff

• An induction is required for every member of staff joining or working within the Trust. It includes those on temporary, short term and agency contracts

Managers/supervisors

• Managers and supervisors hold the responsibility to fulfil the full requirements of the induction process for all new starters in their area of management responsibility and will prepare for the arrival of the new employee in advance of their start date in the department, e.g. arranging work place facilities, identification of their line manager/mentor and preparation of a training plan and e-learning plan. Teams are responsible for the set up a personal file for the individual, including appropriate information gathered as part of the recruitment process and clear records of induction (local and corporate) participation. Each manager or team leader will ensure that a welcome meeting has occurred on the first day in the new team

• The manager/ team leader and new employee will complete all elements of the local induction programme - this will be completed within the required timescales (see Induction Policy: Induction Checklist - appendix one) this is then signed off and the sign off date recorded onto SID
• The induction checklist needs to be signed off by the manager as having been completed on SID. This can be done by clicking on ‘Working Life’, scrolling down and clicking onto ‘Training and Education’ and in the left hand column under ‘Surveys’ scroll down to ‘Completed Induction Checklist’ then respond to the survey as requested. This data will be reported on monthly

• The team manager will ensure the employee is booked onto e-learning or is able to attend any additional mandatory and/or core required training as close as possible to the start of their employment. All mandatory training must be completed within the first six weeks of the start of their employment. Where this is not possible due to exceptional circumstances, the situation must be risk assessed by the manager, and the individual must attend at the first appropriate training

• The manager or nominated person will ensure the new employee is supported with checking the Trust’s training matrix and is fully aware of any core required training expected of that role. They will also ensure the new employee is booked on to attend any additional mandatory and/or core required training as close as possible to the start of their employment. All mandatory training must be completed within the first six weeks of the start of their employment. Where this is not possible due to exceptional circumstances, the situation must be risk assessed by the manager, and the individual must attend at the first appropriate training opportunity

New employees must

• Attend and actively participate in the Trust induction programme

• Notify the Head of Membership if they wish to opt-out of the Foundation Trust membership arrangements

• Take part in a one-to-one PDR meeting with their manager by the end of the first six weeks of employment, to review performance, identify gaps in knowledge, skills and/or experience, and formulate a development plan

Local induction: welcome meeting

• The local induction process should include a meeting between the new staff member and the line manager and/or allocated induction mentor. This must take place on the new employee’s first day in their new department. Usually, this meeting will be on a one-to-one basis, but may be on a group basis where more than one new employee has joined the team. This meeting will be an opportunity to welcome and introduce the new member of staff to the team and service they will be providing, as well as providing important information about how the team works and key processes and protocols. This meeting must use the local induction checklist, which must be fully completed within the first six weeks of employment

Local induction checklist:

• It is mandatory that all new employees complete the local induction checklist with their manager and the manager must maintain a signed copy in the employee’s personal file. A copy of the local induction checklist will be issued by the recruitment service with the letter of appointment for new recruits. This is also available on SID/Policy Appendices for managers to access

• A concise local induction checklist is available for agency, locum and very short term temporary staff (fewer than 15 shifts). All other staff must complete the full local induction checklist. Both versions of the checklist are available from the policy

• An essential part of completing the local induction checklist is to review, plan and ensure the new employee meets all mandatory and relevant core required training for their role. Managers must refer to the mandatory and core required training matrix on SID to ensure all training needs for each role are met
Staffing

Regulation 18 of The Health and Social Care Act (2008) relates to staffing. This regulation ensures that providers deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and to meet all other regulatory requirements set out in the Act.

Staff must receive the support, training, professional development, supervision and appraisals necessary for them to carry out their role responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator which shows that they meet the professional standards needed to continue to practise.

What the CQC told us

- The Trust must provide sufficient and suitably qualified, competent, skilled and experienced staff in order to meet the needs of patient’s and the Trust’s regulatory obligations

- Staffing levels in most community mental health services for children and young people were not safe. There were not enough consultant psychiatrists, nurses, psychologists, therapists or administrators. The number of fixed-term additional staff was insufficient. They had minimal, if any, impact on some waiting times

- The Trust must ensure that staff receive appropriate supervision and appraisals as necessary to carry out their duties

What have we done?

Staffing levels

- In order to fill a number of vacant registered nurse posts and improve bank capacity, the Trust launched the #Discoveryourfuture New Horizons recruitment campaign to promote the organisation as an employer of choice

- The campaign included a number of innovative one-stop shop recruitment events which proved extremely successful - and led to many of our vacancies being filled

- There are now no health care support worker vacancies

- In all but one clinical directorates we have either commenced or have people working to notice to fill vacancies

- We carried out a demand and capacity analysis on CAMHS, based on activity levels and guidance to determine a required level of staffing. We were able to use this to negotiate additional investment from commissioners to support additional multi-disciplinary team staff, consultant psychiatrists and administrators. These posts have taken time to recruit to, but we have moved a great distance and new staff are coming into post. All administrators are in post and although substantive consultant psychiatrists are not yet appointed we have long standing locums in post. This success in filling key posts has had a positive impact on waiting lists

- Newly recruited registered nursing staff will now have a robust programme of preceptorship providing the support they need
• We are continuing to promote strong and effective multi-disciplinary team working with a number of occupational therapy and psychology posts

• We have a rota of all senior nursing staff across a seven-day service, recognising the level of experience amongst our newly recruited registered nurses

• Successful recruitment has led to a reduction in temporary staffing

• We report safer staffing in line with national requirements on all inpatient wards monthly to the Board, and plan to extend this to the Acute Home Treatment and RAID teams

• There are also plans to develop and introduce an e-roster

**Supervision and appraisals**

• Teams have maintained a focus on improving compliance with clinical supervision by ensuring staff have access to individual and group supervision. Team level reporting of supervision rates has supported team leads and enabled more robust monitoring of supervision arrangements and activity. The Trust target for staff receiving supervision is 90%. We have made good progress in this area since September 2015, but more work is needed

• The appraisal process was reviewed at a plenary workshop in April and feedback from staff has been used to develop new paperwork. The overall Trust compliance with PDRs in July was 88% against a target of 90%
Medicines management

Regulation 12 of The Health and Social Care Act (2008) relates to safe care and treatment. The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risks of harm. Providers must assess the risks of peoples’ health and safety during their care or treatment and make sure staff have the qualifications, competence, skills and experience to keep people safe.

Providers must make sure that premises and any equipment used is safe and, where applicable, available in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

What the CQC told us

• The Trust must ensure that incidents are recorded correctly and when errors in care are made they follow the Trust’s Being Open Policy

• All nursing staff should undergo medicines management training

What have we done?

The Trust must ensure that incidents are recorded correctly and, when errors in care are made, they follow the Trust’s Being Open Policy

• All incidents in the Trust are reported via the Safeguard Incident Reporting system, our electronic incident reporting system

• The Patient and Organisational Safety Team shares learning from serious incidents on a monthly basis. These include face-to-face open staff meetings and through Learning Lessons bulletins emailed to staff

• All reported medicines incidents are reviewed by the Clinical Effectiveness Group (CEG), which is responsible for ensuring safe and effective use of medicines

• CEG has established a sub-group entitled the Medicines Optimisation Group, chaired by Louise Jackson, Chief Pharmacist. This has as its mission statement: To ensure a person-centred approach to safe and effective medicines use, enabling people to obtain the best possible outcomes by developing innovative ways of working, within existing resources

• The medication safety thermometer scheme has already been rolled out to all wards. This is a monthly audit of inpatient services where data on omitted medications, polypharmacy and other medication safety issues are collected. The collated information is then sent to respective managers for actions to be taken where required

All nursing staff should undergo medicines management training

• The Pharmacy team now runs mandatory training of all nursing staff on the following topics: medicines optimisation and policy, side-effects of drugs, drug administration and calculations and rapid tranquillisation (once revised in line with new NICE guidelines)

• Plans are afoot to put the above medicines optimisation/medicines management training material online
Every clinical area needs to

• Ensure that all incidents, whether relating to medicines or not, are reported, and in as much detail as possible. This will help ensure patient-centred services of the highest quality and standards. Lessons learnt must be swiftly implemented and monitored.

• Ensure that all members of staff are made aware of the key lessons learnt from incidents reported in the Trust, particularly, but not exclusively, in relation to their areas of professional activities.

• Where possible, as many staff as possible should attend the monthly Learning Lessons sessions held by the Patient and Organisational Safety Team. At the very least, a member from each department should attend and feedback information to other members of the staff in their ward, clinic or department.

• All ward managers to rectify and improve on any aspects of the reports from the medication safety thermometer team.

• Ensure all members of the nursing staff undertake the medicines optimisation/medicines management training run by the Pharmacy team - this is now mandatory.
Combined Healthcare Information Processing System (CHIPS)

Regulation 17 of The Health and Social Care Act (2008) relates to good governance. The intention of this regulation is to make sure that providers have systems and processes that ensure they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A). To meet this regulation, providers must have effective governance, including assurance and auditing systems and processes.

In addition, providers must securely maintain accurate, complete and detailed records in respect of each person using the service.

What the CQC told us

- The provider must ensure that all relevant care records contain risk assessments that are informed by historical risks of the patient
- The Trust must ensure that consent to treatment and information sharing is consistently recorded in the care records
- The Trust must ensure that clinical records are complete, comprehensive and available to staff who need them

What have we done?

- An evidence based risk assessment (University of Manchester Centre for Suicide Prevention) has been developed with clinicians and was made available in December 2015 on the Trust’s CHIPS electronic patient record (EPR) system. Completion rates are monitored by all directorate leadership teams
- A health and social care assessment developed with clinicians has been made available to all staff in CHIPS since December 2015. The assessment includes capacity and consent questions which are reported and monitored for completion by directorates
- Guidance on the completion of paper and electronic records has been agreed by the Trust’s Health Records Group. It was sent out to all areas and has been available on the CHIPS bulletin since December 2015
- CHIPS includes electronic care plans – qualitative audits have been carried out by peer clinicians on the content of the plans and feedback has been given to staff on potential improvements

Every clinical area needs to

- Ensure all staff carry out a risk assessment with service users and make this available for colleagues via CHIPS or equivalent system
- Since December 2015 a health and social care assessment (initial assessment) is carried out with all service users being referred or reviewed and published on CHIPS. This assessment contains reportable items on consent and capacity
- Ensure all service users as a minimum have an identified care co-ordinator, assessment, risk assessment and care plan published on CHIPS
Seclusion

The Mental Health Act Code of Practice 2015 defines seclusion as “the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others”.

It should only take place in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward. In order to ensure that seclusion measures have a minimal impact on a patient’s autonomy seclusion should be applied flexibly and in the least restrictive manner possible.

What the CQC told us

- The Trust did not have a seclusion room meeting the Mental Health Act (MHA) Code of Practice (CoP) 2015 guidance. Patients were being secluded in their bedroom and annexe where the facilities were not appropriate and safe, and did not meet the standard required in the MHA CoP

What have we done?

- A designated seclusion suite has been identified on Ward 1 at Harplands Hospital
- The seclusion suite will be operational by 31 August 2016
- Revised the Trust’s Seclusion and Longer Term Segregation Policy to include the use of least restrictive options

Standards in practice:

Discussions on reviewing policy and procedure have taken place within adult services, learning disabilities (LD) services, neuro and old age psychiatry (NOAP) services and also in CAMHS. The following outcomes have been agreed so far and are included within the revised policy:

- Seclusion should not be a planned event but rather an emergency response to an emergency situation where other less restrictive means of managing are not possible
- The only seclusion room currently will be on ward 1 at Harplands
- LD services, NOAP services and CAMHS have agreed that their service/care model indicates that there will not be a need for seclusion facilities; however, in the rare event that a patient in any of these services is assessed as potentially requiring a seclusion facility, they would be transferred to a service that has seclusion facilities
- The Seclusion and Longer Term Segregation Policy has been updated to also include guidance on less restrictive options including the use of de-escalation intensive nursing support, and how this may be better utilised in all services, but especially LD, NOAP and CAMHS services as the least restrictive option. It is important that staff familiarise themselves with the updated guidance
- A briefing paper containing the key policy changes is being prepared and will be issued to clinicians to ensure full staff awareness. Additionally the Workforce Safety Lead is visiting wards to discuss and highlight changes with staff
- Whilst the current work on the seclusion suite in ward 1 is being undertaken, patients who may require seclusion will be nursed intensively whilst a psychiatric intensive care unit (PICU) bed is sought
- For further information contact Dean Burgess Workforce Safety Lead Manager, on FN1369
Performance development review (PDR)

Regulation 18 of The Health and Social Care Act (2008) relates to staffing. The intention of this regulation is to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. To meet the regulation the providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations.

Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out the responsibilities of their role. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practice.

What the CQC told us

- The Trust must ensure staff are appraised on an annual basis and that this is recorded
- The Trust should ensure that all appraisals record staff members’ progress, development and performance

What have we done?

- Following feedback and evaluations of our PDR processes and paperwork, we held a number of engagement sessions with staff across the Trust. This has resulted in the amendment of our paperwork
- The new paperwork is available on SID and has been widely communicated as the format to be used. The changes relate to the inclusion of the new Trust values logo on the first page, and the re-insertion of the P2B2 Building Blocks model for the talent conversation

What you need to be aware of

- The Trust is committed to supporting every member of staff to apply the required knowledge and skills for their designated role, to develop professional and personal potential and to enable progression
- This also includes bank workers who are not substantive employees of the organisation but should have their performance monitored, reviewed and improved where necessary, ideally through an annual PDR meeting. Bank (only) workers will have their PDR with an appropriate member of the team they work with most regularly. The bank coordinator will monitor completion of bank worker PDRs
- PDR is the Trust’s name for its appraisal system; this is a vital process that encourages staff and their managers to take time out from their day-to-day work responsibilities to reflect on how things have been going and where improvements could be made to the benefit of patients, service users and Trust staff
- PDR focuses attention on how each individual, team, directorate and Trust performance can be enhanced, through the setting of individual objectives (relevant to the person’s role and experience) and the agreement of personal development plans for all Trust staff. The whole purpose of PDR is to support individuals in making the most of their role and supporting improvements
in service to our patients, service users and other customers to deliver high quality health services in line with both the Trust’s values and strategic objectives

• It is really important to us that all employees have a PDR and through this that all staff have the opportunity to develop and improve our service provision. Our staff are our greatest asset and we know that a good, consistent appraisal programme is just one way of providing staff with the time to discuss, reflect and develop both their professional practice and enhance our service provision to our service users

• All line and team managers and team members need to plan into their diaries, the dates and times for their PDRs

• Appraisals should be conducted for every staff member every year and advanced planning will enable the appraisal to be a positive and meaningful PDR experience to all individuals

• Line managers should not delay planning and implementing team PDRs by awaiting their own PDR. As clinical teams have their team purpose and agreed team objectives in place, it is possible to be planning and completing PDRs on a rolling schedule

• Once you have had or delivered an annual appraisal you will need to record this on the PDR record on SID. To do this you will need the assignment number of the person who has received the PDR to activate the record

• The objective of the PDR process is to achieve better results by delivering strong individual and team performance which fosters a culture of continuous improvement

• We do this by clarifying the individual’s role and role purpose, analysing past performance and focusing on the future whilst providing positive and developmental feedback. All individual objectives link to the Trust, directorate and team objectives and this allows us to identify individual training and development needs alongside reviewing support needs and individual stress levels

• In the NHS 2015 Staff Survey, only 61% of Trust staff reported they had received a well-structured PDR. Evidence tells us that, whilst good quality PDRs improve individual and organisational performance, a poorly conducted PDR could have the opposite effect. It is the responsibility of all appraisers to ensure that they deliver a quality PDR experience. Training, support and guidance is available from the Organisational Development and HR teams

• The PDR page and the PDR Policy on SID have an enormous amount of information that both managers and team members will find useful and supportive
Safeguarding

Regulation 13 of The Health and Social Care Act (2008) relates to safeguarding service users from abuse and improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

To meet the requirements of this regulation, providers must have zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- Neglect
- Subjecting people to degrading treatment
- Unnecessary or disproportionate restraint
- Deprivation of liberty.

Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service.

What the CQC told us

- The Trust must adhere to the requirements of the Mental Health Act (1983) Code of Practice (2015) with regards to seclusion
- The Trust must ensure informal patients are aware of their rights to leave the ward and that there is appropriate legal authority in place if staff prevent informal patients from leaving
- The Trust must ensure that all staff receive the appropriate safeguarding training to the required level
- The Trust must ensure that all incidents are recorded correctly and when errors in care are made they follow the Trust’s Being Open (incorporating Duty of Candour) Policy

What have we done?

- Health Intercollegiate Level 3 training is available both electronically and face-to-face - additional face-to-face training has been commissioned from an external provider

Every clinical area needs to:

- Support registered staff to attend Level 3 training either face to face or via ESR
- Ensure that all staff are aware of how to make both adult and child safeguarding referrals
- Ensure that all staff know when it would be appropriate to make a referral for safeguarding
- Ensure that staff know how to recognise abuse
- Ensure staff know how to contact the safeguarding team for advice and information

Every clinical area needs to consider the following:

- When a person is admitted to hospital or a community service is safeguarding considered?
- When a person is discharged from either hospital or a community setting is safeguarding considered?
- When leave is being considered during a hospital admission teams must consider the safety of children who may be at home, as well as the safety of the service user who may be returning to an abusive relationship and safety of family members
• Are the names, ages and schools of children in the household/family recorded in notes

• If there are any safeguarding issues for either adult or child is it recorded in the care plan?

• Is the impact of parents’ possible relapse on the child recorded in the staying well plan including contingency planning where appropriate for childcare?

• If there are current adult safeguarding concerns is the appropriate risk marker utilised on CHIPS?

• If there are current child protection or child in need processes in the household is the appropriate risk marker utilised on CHIPS?

• Are safeguarding issues (both adult and child) recorded in caseload management discussions?

• Are caseload managers/ team leaders/ ward managers aware of all the safeguarding issues within their team?

• During child safeguarding processes are staff members working with the multi-agency team and the family for the best outcomes of the children?

• If unable to attend meetings are written reports provided?

• Are staff aware of the availability of safeguarding supervision both for teams and ad hoc on an individual basis?

• Do staff know how and when to refer to PREVENT?
Policies

Regulation 17 of the Health and Social Care Act (2008) relates to Good Governance. The intention of this regulation is to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A). To meet this, providers must have effective governance, including assurance and auditing systems and processes. In addition, providers must securely maintain accurate, complete and detailed records in respect of each person using the service.

As part of their inspection process the CQC use the following five questions to assess the quality of our services:

• Are they safe?
• Are they effective?
• Are they caring?
• Are they responsive to people’s needs?
• Are they well-led?

Within these five questions there is a further set of detailed criteria known as key lines of enquiry to enable each category to be fully evaluated. We received a rating of ‘requires improvement’ for well-led at our last inspection.

By well-led, the CQC refer to leadership, management and governance of the organisation and assurance in the delivery of high quality person centred care which supports learning and innovation, and promotes an open and fair culture.

Governance includes the establishment of policies which are regularly reviewed to ensure that continuous monitoring meets with both local procedures and national legislation and guidelines. In essence, it is the systems and processes which provide us with a framework of assurance.

What has the Trust done around policies?

• Local consultation is held within relevant meetings or groups regarding any new or revised policy
• In line with the governance framework the policy then requires approval from the relevant committee and ratification from the Trust Board
• The Policy Working Group review all policies received to check for quality, consistency, equality and inclusion and any training impact
• A weekly CQC Compliance and Quality Group has been set up to look at forthcoming clinical policies requiring update or renewal
• As some policies can be quite lengthy the above group has designed a Policy, Practice, Training and Issue (PPTI) summary to provide a handy guide of the key points, responsibilities and training contained within any specific policy

All new or revised policies

• All new or revised policies ratified by the Trust Board will be uploaded onto SID. Staff will see a reminder in News Round encouraging them to regularly check the intranet for any new policies.
• The relevant policy will appear with a “new” flag symbol beside it.
New/updated policies include

Critical Incident Stress Management – extend three months

1.71 Duty to Co-operate with MAPPA – extend to 31 October 2016

4.18a Risk Management Policy

1.80 Resuscitation Policy

1.03 Medicines Management Policy

5.32 Serious Incident Policy

1.12a Safeguarding Policy

7.1 Confidentiality of Employee and Patient Records

MHA06 Guidance on conflict of interest

MHA17 Procedural guidance for preparing mental health tribunals

MHA20 Procedure for IMHA Service

MHA 13 Staffs and Stoke S135 (protocol for support and management of MHA assessment on private premises)

MHA14 Staffs and Stoke S136 Interagency Policy

1.68a Management of S136 at Harplands Hospital

Management of Probationary Periods Policy

Medical Appraisal Policy

Disclosure and Barring Service Policy

Induction Policy

Recruitment and Selection Policy and Procedure

Hand Hygiene Policy

IC19 Clostridium Difficile Policy

Inoculation Policy

Policy and Procedure for the Safe and Supportive Observation and Engagement of Patients at Risk

Patients Missing From Hospital/Absent Without Leave Policy
Dual diagnosis

Dual diagnosis is defined as an individual with a co-existing mental disorder who has harmful or dependent substance use. The Trust’s policy stresses best practice guidance - that is: all services should be inclusive of those with co-existing need and should not exclude on the basis of dealing with primary concerns first. There is increasing evidence that providing flexible approaches to treatment and support utilising the Care Programme Approach (CPA), regardless of primary need, is the most effective option.

Support for service users and care staff is offered in the following ways:

- Dual diagnosis training is available, which can be delivered flexibly in-house, individually or at a dedicated training event

- We have a network of dual diagnosis champions (new recruits are welcome)

- Evidence-based screening tools for alcohol and substance misuse form a part of all routine initial assessments

- Broad intervention strategies are utilised to help individuals negotiate all stages identified in Prochaska and DiClemente’s spiral of change model. A focus on supporting individuals through pre- and contemplative phases is as important as delivering treatments when an individual accepts the need for action

- The Policy appendix offers a mapping tool to support staff with this

- The Early Intervention Team have worked with service users and carers to develop intervention cue cards for each stage of the model (these are available to other services)

- We continue to be a key provider of substance misuse services and a number of specialist professionals within this directorate are available to support with consultation and advice

- Best practice guidance is available in areas such as drug screening and the management of substances in acute wards

- A consultant nurse in dual diagnosis provides supervision, training and direct clinical support across our services

- More information is available from Chris Fieldhouse, Consultant Nurse Dual Diagnosis, at christopher.fieldhouse@northstaffs.nhs.uk
We would like to thank all our staff for their support and participation in our CQC inspection.