Review of compliance

Birmingham and Solihull Mental Health Foundation Trust Various locations across the trust	
Region:	West Midlands
Location address:	Trust Headquarters B1, 50, Summerhill Road Birmingham West Midlands B1 3RB
Type of service:	Service for people with mental health needs.
Date the review was completed:	February 2011
Overview of the service:	The trust provides a wide range of inpatient, community and specialist mental health services for people from the age of 16 upwards. These services include: rehabilitation, home treatment, community mental health services, assertive outreach, early intervention, in patient services, day services and mental health wellbeing services.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that the trust was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Staffing
- Supporting workers
- Notification reporting

How we carried out this review

We reviewed the information we hold about this provider. We visited six different locations in the trust, the Bruce Burns Unit, Lavender Ward (this was a joint visit with a Mental Health Act Commissioner), Reservoir Court Assessment Ward, the Linden Resource Centre, the Zinnia Centre and the community centre linked to Reservoir Court between 31 January 2011 and 3 February 2011. We observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

What people told us

People who use the services the trust provides were satisfied with the mental health care they received. They felt that the staff were very knowledgeable about their mental health needs and treatment. They told us they were able to speak to staff whenever they needed to both as inpatients and as community patients. They felt well supported by trust staff.

Comments made by patients included:

"They (psychiatrist and nurse) support me to make decisions about my care, suggestions are made and we discuss them."

"I am not forced to do anything I don't want to do or I don't feel ready for."

"I have a care plan, this was discussed with me and I have signed it."

"Part of my care has involved helping me to get voluntary work and now I am doing a degree."

"My named nurse has also told me that my care plan is due for review."

"They have literally saved my life."

What we found about the standards we reviewed and how well the trust was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

There is a lack of consistency in care practices across the trust. People are not always experiencing effective, safe and appropriate care treatment and support that meets their needs. Overall, we found that improvements are needed for this essential standard.

Outcome 7: People should be protected from abuse and staff should respect their human rights

People are not fully protected from abuse as the current components of the safeguarding system are not formally monitored and reviewed to ensure an effective safeguarding system is in place. Overall, we found that improvements are needed for this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People's health and welfare needs are not consistently being met as at some locations there are not always sufficient numbers of staff to do so. Overall, we found that improvements are needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People's safety and health and welfare needs are compromised as not all staff are properly trained or supervised. Overall, we found that improvements are needed for this essential standard.

Outcome 18: The deaths of people who use services are reported to the Care Quality Commission so that, where needed, action can be taken.

Events that affect the welfare, health and safety of people using the service are not being appropriately reported to the Care Quality Commission or the National Patient Safety Agency. Overall, we found that improvements are needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We were able to speak to one person using community mental health services at the Linden Centre. At the Zinnia Centre, people were involved in clinic or therapy sessions. At Reservoir Court Community Centre no patients were using the centre on the day of our visit. For these reasons it was not possible at the time of our visit to speak to people who use the services of the Zinnia and Reservoir Court community centres.

The person we spoke to at the Linden Centre told us that they were extremely happy with the care they received. This person knew their consultant psychiatrist and named nurse very well. They told us how they were involved in the planning of their care. "They (psychiatrist and nurse) support me to make decisions about my care, suggestions are made and we discuss them." "I am not forced to do anything I don't want to do or I don't feel ready for." "I have a care plan, this was discussed with me and I have signed it."

"Part of my care has involved helping me to get voluntary work and now I am doing a degree."

"My named nurse has also told me that my care plan is due for review."
This patient expressed their concern about the changes being made in the way care

is delivered. The patient was concerned about having different professionals looking after them if admitted to hospital. This person told us that the community professionals who know about their mental health condition and history should still be involved in their care.

The patients on the wards told us they were happy with the staff caring for them.

" They are very good, very supportive"

"They have literally saved my life"

" I can talk to the nurses whenever I need to and they help me"

Other evidence
We spoke to the psychiatric nurse involved in the care of a patient who had expressed concerns about recent changes. They told us that the focus of the care they provide is on enabling people that use the service to make informed decisions on the treatment they receive. This includes making choices about their rehabilitation into the community. For example, this could be preparing for employment, socialising or further education courses. The nurse also confirmed that care plans are reviewed monthly or more often if required.

We spoke to two consultant psychiatrists working within the Linden and Zinnia community centres. The manager and one of the consultant psychiatrists at the Linden centre told us how every effort is being made to help all the professionals linked to the Centre to work effectively as a multidisciplinary team. They told us that multidisciplinary team meetings take place where the care of patients across departments is discussed. The consultant psychiatrist told us that he meets with the inpatient consultant psychiatrist linked to the centre for half a day each week. This has helped to maintain continuity of care, good working relationships and promote better outcomes for the people that use their services. This is good practice. It is not a practice that has been implemented across the trust.

In two of the community areas we visited, namely the Linden and Zinnia community centres there were excellent opportunities for activity and therapy programmes for patients. These programmes were fully established at the Linden Centre. Sessions undertaken in the centre include art, cooking, healthy lifestyle and drop in sessions. External agents involved include the Citizen's Advice Bureau (CAB) and the Birmingham Disability Resource Centre (BDRC). The latter group were involved in helping people to secure voluntary work placements and also to access National Vocational Qualifications (NVQ) and formal qualifications.

Programmes at the Zinnia centre were developing well especially for community patients. More work was needed to establish meaningful and effective programmes for inpatients at the Zinnia Centre. The community services for older people at Reservoir Court were in the process of moving into the building. We met and spoke with the team manager who will be involved in implementing activity and therapy programmes in the centre. Plans based on feedback from people who use the service and looking at best practice in other older people mental health community centres were being looked at.

We saw that people who used the community and inpatient ward services had care files. Files were stored in secure locked areas. We had concerns about the level of confidentiality afforded to patients when they visited the Linden Centre. The reception is an open area where it would be difficult to maintain confidentiality when speaking to patients. The door to the outside constantly opens and the area where patients sit and wait is small and not comfortable. Staff had tried to make it comfortable but it is not a suitable area to talk to patients no matter how discreet and in a way that respects their privacy. This area is also not a suitable area for patients to sit if their mental health has deteriorated.

Information in patient care files shows that they are completed by the multidisciplinary team of staff that work within the locations visited for this review. This was good practice. It provided a complete picture of the care received by people using the services.

The care files did not clearly demonstrate what discussions had taken place between the professional and the patient to involve them in planning their care. This was identified in both the community and on the wards.

The risk assessment tool in use was complex. It was a lengthy document. It did not allow staff to clearly identify risks or areas of vulnerability that were specific to the individual people in their care.

A care file we looked at in the Zinnia community centre did not contain a copy of the person's care plan. The named community psychiatric nurse printed a copy of the care plan from the computer system. We were told that the patient had signed the original copy of the care plan. We asked what measures were in place to prevent changes being made to a patients care plan. It was not clear that the patients computerised care plan was protected to prevent them being changed without the permission or involvement of the patient.

The ability of staff to recognise and respond to deteriorating physical health needs was one of the information triggers for initiating this review. Our conversations with staff showed us that they were very positive about their work. They had a good understanding of their patient's and their mental health needs. This was not always the case when staff were asked about the physical health needs of people in their care.

For example during our visit to Lavender Ward, Zinnia Centre a patient observed by us and the Mental Health Act Commissioner throughout the day was clearly unwell. The patient also said that they were not well. As the day went on the patient became more irritable, angry and incoherent. We observed staff management of the patient. The strategy used was to keep moving the patient on by directing them to other areas in the ward. Later that day the patients behaviour became worse and they smashed some plates. Alarms carried by staff went off and their response was to inject the patient with a sedative drug. We were told that these measures had also been taken with this patient the day before due to a similar episode.

The ward manager told us that the patient was diabetic and their blood sugar readings were high. We asked him how often blood sugar levels were checked on the ward. We were told once a day. We asked if a doctor or the specialist diabetic

nurse had been informed. The ward manger said that he would mention it to the doctor during the ward round the following day.

We saw no evidence to show that action had been taken to stabilise the patients' blood sugar levels. This could have been through obtaining medical advice or to monitor the patient's blood sugar levels on a more regular basis. It was suggested that the patient's unstable blood sugar levels were contributing to their behaviour and also making them feel unwell. There was no evidence to show that this possibility had been considered by staff on the ward.

Responses from staff in the community when we asked what they would do if they saw that a person's physical health had deteriorated when they visited them in their home varied. Staff advised that on the first visit to the home patients would be encouraged or told to contact the doctor themselves. An example of a patient who presented with left sided facial weakness when visited in their home was given to us. Staff told us that the patient was left at home and told to visit their GP. The member of staff returned to see if the patient had been to see the GP. The patient had been to see the GP but was sent home and told nothing was wrong. Subsequently the patient had a stroke at home and was admitted to hospital.

Discussions with staff and information in care files show that patients have baseline observations recorded during the admission process. This should provide staff with baseline information from which to monitor any improvement or deterioration in a person's physical wellbeing.

The Bruce Burns Unit has recognised the need for physical health care checks and has implemented a weekly "health clinic" on the ward where each patient has their observations reviewed and recorded. This includes their weight, blood sugar levels, blood pressure and respirations. This is good practice. It helped staff to recognise early symptoms of ill health and take action to prevent further deterioration. This good practice was not in place at the other locations we visited.

Staff told us that they liked the changes made for delivering care as they know who the psychiatrist is. The process for ward rounds and meetings has also been made easier. The new system of working involves defining the roles of professionals within the community and inpatient areas. This means that patients can expect to receive treatment and care from professionals that specialise in community care or inpatient care.

For example patients will receive treatment and care from a community consultant psychiatrist when out in the community setting. If a patient has to be admitted to hospital they will be cared for by a consultant who specialises in inpatient care. Staff told us that there have been problems when doctors were shared by two units. Staff described a recent incident where a new patient was admitted to Reservoir Court but no doctors were on hand to admit the patient as they were at Juniper. This led to a complaint being made by the patient's family.

Several inpatients and a community patient told us that they are not happy with the new system. They felt there was no continuity of care as they move between community and inpatient mental health care. Patients told us that the lack of continuity means that the different professionals they come in contact with may not

know the details of their mental and physical health history. There was also the potential for insufficient or non communication of relevant information between professionals.

We were told about the various meetings that take place within and between departments. One of which is the multidisciplinary team meetings. Ward staff were asked what processes were in place to ensure that there was good communication between hospital and community at the time of discharge. Staff told us about the need for good communication, but were not clear what the processes were.

Staff told us that there were occasions when they had accepted a new patient out of their catchment area. There had been situations where lack of information from the community teams had placed people at risk. The information had to be chased up by staff and had taken a couple of days before it had been received.

Ward staff told us that there were sometimes similar problems when discharging patients to another area. For example a patient on Lavender Ward was discharged but needed a community assessment before discharge. Ward staff reported that despite numerous telephone calls it took a further 48hrs before someone from the community team came and assessed the patient.

Staff reported that they have difficulty accessing psychiatric intensive care (PICU) beds in the region. They often find themselves having to manage the patient on the ward. This has been disruptive for other patients on the ward and has resulted in staff taking their focus off the other patients.

Bed management was an issue. We were told by two senior staff that an informal practice of releasing beds before a patient is fully discharged from the ward is used. We have since been informed by the trust that this is a formal bed management practice used across the trust. For example on Lavender Ward there were 16 beds. On the day of our visit all the beds were occupied. In addition there were 6 patients on leave. The patients on leave were all detained under the Mental Health Act. We asked staff what would happen if any of the patients needed their bed due to a crisis whilst on leave. We were told that a bed would have to be found elsewhere (another hospital, which could be outside of the person's place of residence) for the patient. This raised a number of concerns in relation to continuity of care for patients.

Staff told us that they did not always have the staff available to escort patients on leave. This had led to patients being denied their leave as required under the Mental Health Act. This is an important part of a patient's treatment that had been denied to them. We were told that this had led to patients expressing frustration and anger resulting in incidents occurring on the ward.

A number of patients complained about the quality of breakfast on Lavender Ward. Cereals, porridge and toast are provided to the patients. If they required a cooked breakfast this was available at the Venue (a café facility for patients and staff). Patients were charged for this. Inpatients at the other locations we visited were not charged for a cooked breakfast.

Most of the patients were from an ethnic background, mainly Asian. The breakfast offered is cereal and toast. Some patients told us this would not be what they have

for breakfast at home. The trust provided meals during the day, which catered for the dietary needs and preferences of people from different ethnic groups. The trust was not providing this choice at breakfast.

Our judgement
There is a lack of consistency in care practices across the trust. People are not always experiencing effective, safe and appropriate care treatment and support that meets their needs. Overall we found that improvements are needed for this essential standard.

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are major concerns with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We did not speak to any patients receiving care in the trust about this outcome group.

Other evidence
One of the triggers for this review was information received from the trust about a small number of suicides and homicides involving people using mental health services. This review is not an investigation into these events. We have used this information to focus part of our review on how well the trust safeguards vulnerable adults who use its services.

We found that staff on the wards and in the community had a basic awareness of safeguarding and what they think they should do. There was some confusion amongst staff over what constitutes a safeguarding referral and how to recognise it. Information we received from the trust stated that 55% of staff have had 3 yearly safeguarding updates. Staff told us the main emphasis was on safeguarding training related to children. The main group of patients served by the trust are younger adults of working age and older people. Staff we spoke to told us that they had attended safeguarding updates.

Our conversations with the trust indicate that there was no formal decision making

process in place for safeguarding. We were told that informal conversations take place with the local authorities. The practice is for staff on the wards to refer suspected safeguarding issues directly to the local authority. The trust made over 1100 notifications coded as "abuse" to the National Patient Safety Agency (NPSA) in the period April 2010 to December 2010. The number the trust told us about during our conversation was much lower. The trust were not aware of what had or had not been referred to a local authority as suspected abuse. The appropriateness of referrals was not monitored. There was no overall system for ensuring that lessons were learned from safeguarding referrals and their outcomes. We were told that a system was being introduced to change this.

The Mental Health Act Commissioner raised concerns about a patient after reading the patients history, stretching back five years. It was recorded in 2006 that the patient's father managed their benefits and also kept them and their mother locked in the house. In 2009 similar issues were raised again in relation to financial and emotional abuse. A safeguarding case conference had been held. The current care plan stated 'It has been reported patient 3's father taking their benefits and only allowing small amounts of money….'

The commissioner found that there was no information to show the outcomes and action that had been taken as a result of these safeguarding concerns.

Staff we spoke to had a limited understanding of Deprivation of Liberty Safeguards (DoLS). The trust has a policy of having locked wards. There were no assessments to demonstrate how this impacted on informal patients with reference to DoLS or the steps that had been taken to ensure that people had not been unnecessarily deprived of their liberty. We asked the trust how many DoLS (Deprivation of Liberty Safeguards) had been made. We were told one. Staff told us that they had received DoLS training. They were not able to demonstrate a clear understanding of DoLS. For example that they were not able to identify a possible deprivation and what they should do if this was identified.

Solihull NHS Care Trust, who commission services from the trust, told us that they do not feel they are getting the appropriate 'Serious Incident' notifications from the trust. They do not feel confident that appropriate improvement actions are taking place as a result of serious incidents.

We met with the trust's safeguarding lead as part of our visit. The outcome of which demonstrated that the trust needs to review their current safeguarding processes. This review should ensure that the trust is confident that:

•Staff have an understanding of the differences between serious untoward incidents, notifications and safeguarding.
•The systems for monitoring and reviewing safeguarding incidents and acting on any feedback are strengthened
•Current BSMHFT polices and procedures for safeguarding reflect best practice and systems are in place for lessons to be learnt
• A performance management/audit system is implemented to ensure that safeguarding policies and procedures are being adhered to
•A formal and regular reporting process to the local safeguarding partnerships is established

•A system is in place for ensuring a higher uptake of safeguarding training across the Trust
•The trust is sure that staff are receiving training that helps them to handle safeguarding appropriately.

Our judgement
People are not fully protected from abuse as the current safeguarding system within the trust is not formally monitored and reviewed to ensure that an effective safeguarding system is in place. Overall we found that improvements are needed for this essential standard.

Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
The patient we spoke to in the community told us that they were able to gain access to staff whenever they needed to. They told us that they could phone the centre for support if needed or staff would visit them at home. The centre is not open after 5.00 pm during the week and is closed at weekends. We therefore asked the patient what support is available to them when the centre is closed. They told us that they have a card that provides contact numbers for the hospital. We found that the community centres and wards had good links and relationships with voluntary and external advocacy services.

Staff in the community told us that they are looking at the benefits for patients if they were to provide a weekend service. If a need is identified they will put a business case forward to the trust board.

Patients we spoke to on the wards told us they could talk to a member of staff whenever they needed to, and they felt supported by the staff team caring for them.

Other evidence
Managers for the community units and staff working in them told us that staffing levels were sufficient. We found staff were very professional in their approach. We were impressed with the staff we spoke to, their attitude and knowledge of mental health practices was of a good standard. There was a very good team work ethic

across all the sites. All staff told us that they felt well supported by their managers. The Linden Unit community manager and consultant psychiatrist told us about the work they were doing to provide an integrated service for patients. Varied meetings take place these include multidisciplinary, management, understanding the different professional roles and how they overlap and discussing patients.

Staff on Lavender ward told us about their concerns about staffing. The ward is currently run on four staff per shift, two qualified and two nursing assistants. Staff felt that this impacted on the care they gave to their patients. Section 17 leave as stipulated under the Mental Health Act was often denied as a consequence of staffing levels. Staff told us that the reason for this was there were not sufficient numbers of staff available to escort patients on leave.

We were told by qualified staff that they spend most of their time doing paperwork. We observed that this was the case during our visits to all the ward areas. Qualified staff were in the office doing paperwork leaving nursing assistants on the wards with the patients. One staff member said “I didn’t train to be a secretary”. Qualified staff told us they had little or no time to implement 1:1’s or group sessions with patients for therapy and treatment. They have to rely on the nursing assistants to tell them what is happening. This information was confirmed by the nursing assistants working at the time of our visits.

At Reservoir Court and the Bruce Burns Unit there were very good activity and therapy programmes running. These were supported by occupational therapists and activity workers. There was not the same level of activity and therapies for patients on Lavender Ward. We were told that the reason for this was due to the ward not having an occupational therapist. The Zinnia centre has an area called the ‘Venue’ where activities take place. We did not see any activities taking place at the time of our visit, although patients did tell us that when activities do take place they do enjoy them.We observed patients wandering around or sitting by themselves.

Nursing assistants told us they wanted to join the hospital's nursing “bank” but are having problems. They had been told they needed to get another criminal records bureau check completed (CRB check) completed. These staff were already employed by the trust and should have the outcome of a CRB check on their file. This means that at times bank and agency staff are working on the wards who do not know the patients they are caring for. Patients have therefore experienced an avoidable reduction in the continuity of their care. Staff have told us that they did not have the time to make bank and agency staff aware of everything they need to know in terms of potential risks for each patient. This has presented a risk to both patients and staff, in the event of emergency situations.

Our judgement
People’s health and welfare needs are not consistently being met as at some locations there are not always sufficient numbers of staff to do so. Overall we found that improvements are needed for this essential standard.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
The patients we spoke to told us that they felt the staff were very knowledgeable about their care.

Other evidence
The managers for the three community centres told us about the training that staff had completed. In our conversations with staff they confirmed that they had received mandatory training and also completed courses in counselling related to mental health. Mandatory training attended by staff include health and safety, equality and diversity, food hygiene, manual handling, personal safety and fire safety.

The training matrices we looked at showed the dates when staff were next due to attend planned mandatory training sessions. These showed that most staff were booked to receive mandatory training for the next three years. Our concerns were that apart from the training matrix for Linden Centre we could not tell when staff had last received training. The matrix showed limited training for staff related to mental health conditions. There was no documented evidence of training in relation to physical conditions and deterioration of a person's physical health. The Statutory and Mandatory Training Prospectus given to us by the trust does not include training on specific physical illnesses. This would support staff in managing physical illnesses presented by the people they care for, such as diabetes.

One of the areas we looked at was related to the deterioration of the physical

wellbeing of people receiving care. Staff spoken with at all locations were able to describe very confidently what they would do in the event of an emergency situation and confirmed for us that they had received cardio-pulmonary resuscitation (CPR) training.

We found that clinical supervision was inconsistent. Some areas have regular supervision and staff spoke positively about their supervision experience. This was especially evident in the community areas. Here staff described having clinical supervision and management supervision sessions monthly. Group supervision was used as a learning experience this involved discussing incidents that had occurred, patient treatment and complaints.

Staff on Lavender Ward told us that supervision was irregular for them. They said that the day to day running of the ward prevents supervision from happening. Staff on Bruce Burns Unit and Lavender Ward told us there was not the time or the staff available for them to leave the ward. As a result staff ward meetings are also inconsistent.

Staff had received training in DOLS. Discussions with staff indicated that their understanding of DOLS was limited. Staff did not know when to implement a DOLS order. The trust needs to make sure that training delivered ensures that:

- Staff are aware of whom DOLS applies to
- Staff are able to identify a possible deprivation
- Staff know what is required should they identify a potential deprivation

Staff told us that they need more mental health training. This was referred to in relation to different mental health illnesses, symptoms, coping mechanisms and treatments.

Our judgement
People's safety, health and welfare needs were compromised as not all staff are properly trained or supervised. Overall we found that improvements are needed for this essential standard.

Outcome 18:
Notification of death of a person who uses services

What the outcome says

This is what people who use services should expect.

People who use services:

- can be confident that deaths of people who use services are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are moderate concerns with outcome 18: Notification of death of a person who uses services.

Our findings

What people who use the service experienced and told us
We did not speak with any patients receiving care in the trust about this outcome group.

Other evidence
Managers for the community centre and inpatient wards we visited told us that incident forms are completed for all incidents that occur in the centre or within the community. These are forwarded to the appropriate people in the trust. The manager at the Linden Centre also told us that these are used in meetings, supervision sessions as a learning tool and discussion point.

Staff told us that they complete incident records in great detail and tend to report everything. Ward and community managers said they would rather staff over report than under report and miss something.

There were issues with how data was managed and analysed. The reports are coded by staff in the risk management department before being forwarded to the NPSA. We were told that these are coded in line with the requirements and categories issued by the NPSA. Coding is also completed based on what the staff working in data management consider to be the best fit.

We discussed some of the death notifications we had received from the trust. These had either been incorrectly coded or were considered should not have been reported to the NPSA in the first place. For example, a notification stated in the coding category that there was a lack of skilled staff, a second stated infection control incident as the category, neither of these were correct.

The trust should have a system in place for checking and auditing all notifications that fall under outcomes 18, 19 and 20 of the Health and Social Care Act 2008 before incident report information is forwarded to the NPSA.

Our judgement
Events that affect the welfare, health and safety of people using the service are not always being appropriately reported to the Care Quality Commission or the National Patient Safety Agency. Overall we found that improvements are needed for this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Assessment or medical treatment of persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury. Diagnostic or screening procedures	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010	Outcome 4: Care and Welfare of people who use services
	How the regulation is not being met: There is a lack of consistency in care practices across the trust and people are not experiencing effective, safe and appropriate care, treatment and support that meets their needs	
Assessment or medical treatment of persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury. Diagnostic or screening procedures	Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010	Outcome 7: Safeguarding people who use services from abuse.
	How the regulation is not being met: People are not fully protected from abuse as the current components of the safeguarding system are not formally monitored and reviewed to ensure an effective safeguarding system is in place.	
Assessment or medical treatment of persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury. Diagnostic or screening procedures	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing.
	How the regulation is not being met: People's health and welfare needs are not consistently being met as at some locations there are not always sufficient numbers of staff to do so.	

Assessment or medical treatment of persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury. Diagnostic or screening procedures	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers.
	How the regulation is not being met: Peoples safety and health and welfare needs are compromised as not all staff are properly trained or supervised.	
Assessment or medical treatment of persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury. Diagnostic or screening procedures	Regulation 16 of the Care Quality Commission (Registration) Regulations 2009	Outcome 18: Notification of death of a person who use services.
	How the regulation is not being met: Events that affect the welfare, health and safety of people using the service are not always being appropriately reported to the Care Quality Commission or the National Patient Safety Agency.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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