Requires improvement

Kent and Medway NHS and Social Care Partnership Trust

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

Quality Report

Trust Headquarters, Farm Villa,
Hermitage Lane,
Maidstone,
Kent, ME16 9PH.
Tel: Tel: 01622 724100
Website: www.kmpt.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXY3P	Littlebrook Hospital	Amberwood Ward	DA2 6PB
RXY3P	Littlebrook Hospital	Cherrywood Ward	DA2 6PB
RXY3P	Littlebrook Hospital	Pinewood Ward	DA2 6PB
RXY3P	Littlebrook Hospital	Willow Suite (PICU)	DA2 6PB
RXY6Q	Priority House	Boughton Ward	ME16 9PH
RXY6Q	Priority House	Chartwell Ward	ME16 9PH
RXY6Q	Priority House	Upnor Ward	ME16 9PH

Summary of findings

RXY03	St Martins Hospital	Bluebell Ward	CT1 1AZ
RXY03	St Martins Hospital	Fern Ward	CT1 1AZ
RXY03	St Martins Hospital	Foxglove Ward	CT1 1AZ
RXY03	St Martins Hospital	Samphire Ward	CT1 1AZ

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- Cherrywood ward at Littlebrook Hospital was not complying with guidance on same-sex accommodation.
- Patients' bedrooms on the psychiatric intensive care unit, Willow Suite, contained multiple ligature risks.
- Some areas of the service had excessive vacancies and relied heavily on bank and agency staff. Some staff did not meet the trust's target for completion of mandatory training or have access to regular supervision.
- Patients' risk assessments were not always reviewed or updated following risk related incidents. Episodes of patient being secluded were not always recorded in line with the trust's seclusion policy.
- Patients' care plans did not always address a full range of needs; were not always recovery focussed and patient involvement was not always recorded. Psychological assessments or treatment was not available to patients on the psychiatric intensive care unit, Willow Suite.
- Staff did not always have sufficient knowledge of the Mental Health Act Code of Practice and the Mental Capacity Act. Documentation was not always completed in line with these Acts.
- Staff were not always using systems in place to document and monitor when patients were taking Section 17 leave.
- The trust's no smoking policy was presenting issues for patients and staff. These included episodes of physical aggression, inconsistencies in following the policy, and increased risks of patients smoking in bedrooms. Patients' outside areas were not always accessible or therapeutic.
- Some managerial decisions had been counter-productive. These included salary incentives that excluded some staff; lack of clarity on wards providing same-sex guidance; and inconsistencies in following the no smoking policy.

However:

- All wards had clinic rooms and emergency medical equipment for staff to respond to medical emergencies. Seclusion rooms were equipped in accordance with the Mental Health Act Code of Practice.
- All ward environments were clean and well-maintained with systems in place that ensured environmental issues were identified promptly. Patients and staff had access to alarm systems to ensure they could summon support if they felt at risk.
- Staff had good observation systems in place to ensure that patients were kept safe. Staff were able to manage distressed patients safely. They had access to calming rooms and only used restraint as a last resort. Staff received restraint training that eliminated the need to restrain patients in a face down position.
- Staff had a good understanding of the processes of incident reporting and raising safeguarding issues. The service regularly discussed incidents and learnt from them.
- Patients received ongoing monitoring of their physical health needs from registered general nurses who were trained in recognising physical health concerns. The service received support from pharmacists to ensure that medicines were managed effectively.
- The service had recently introduced therapeutic staffing. This model integrated occupational therapists and psychologists into staff teams and provided patients with a wider range of structured activities seven days a week.
- Staff had regular meetings and handovers where they discussed patients' care needs in detail.
- Staff treated patients with dignity and respect. Staff had a good understanding of patients' needs and listened to their views. Patients had access to recovery groups that encouraged them to maintain their independence. The service was committed to involving families and carers.
- The service employed discharge facilitators to address issues preventing discharge. In the last six months the

Summary of findings

service had significantly reduced its use of private beds. They also employed dedicated staff to improve patients' access into the trust's psychiatric intensive care unit.

- Patients had access to a wide range of therapy rooms and activities which were available seven days a week. Patients were able to access their bedrooms during the day and had access to mobile phones and rooms to see visitors in private.
- All wards displayed a wide range of patient information including how to complain. Patients knew how to complain and staff knew how to manage complaints. Patients could access interpreters and chaplains and were provided with information on local services.
- Staff knew the trust's vision and values and agreed with them. They enjoyed their roles and morale was generally high. Staff felt supported by managers and colleagues and had opportunities for career progression.
- Ward managers had effective governance systems to enable them to monitor training, supervision and staffing levels. Staff had the use of effective systems to record incidents and safeguarding issues.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as requires improvement because:

- Patients' bedrooms on the psychiatric intensive care unit, Willow Suite, contained multiple ligature risks. These were identified in environmental risk assessments but the environment was unsuitable for patients presenting with a high risk of self-harm.
- Cherrywood ward at Littlebrook Hospital was not complying with guidance on same-sex accommodation.
- Some areas of the service had excessive staff vacancies. This meant they relied on support from bank and agency staff. The majority of these staff did not have access to mandatory training or the trust's electronic patients' records system. This put increased pressure on regular staff members.
- Some staff did not meet the trust's target for completion of mandatory training. Staff also felt that some of the training provided through e-learning did not sufficiently meet their learning needs.
- Patients risk assessments were not always reviewed or updated following risk related incidents.
- Episodes of patients being secluded were not always recorded in line with the trust's seclusion policy.

However:

- All wards had fully equipped clinic rooms which contained equipment for staff to respond to medical emergencies.
- Seclusion rooms at Littlebrook Hospital and Priority House were equipped in accordance with the Mental Health Act Code of Practice.
- All ward environments were clean and well-maintained. Some wards had been recently refurbished with others having refurbishments planned for the near future. Systems were in place that ensured any environmental issues were identified and reported for maintenance.
- Patients and staff had access to alarm systems to ensure they could summon support if they were at risk.
- Staff had good systems in place to ensure that patients were observed at levels appropriate to the support they needed.

Requires improvement 

Summary of findings

- Staff were skilled in calming distressed patients in the least restrictive way. They had access to calming rooms and only used restraint as a last resort. When patients needed to be restrained, staff had been trained to do this safely and without the need to restrain patients in a face down position.
- Staff had a good understanding of safeguarding issues. They were aware of how to escalate concerns and had robust support from safeguard leads if they needed advice.
- Staff were able to identify incidents and were aware how to report them. The service displayed an open culture of discussing incidents and learning lessons from them.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Patients' care plans did not always address a full range of needs and were not always recovery focussed.
- Patients at the psychiatric intensive care unit, Willow Suite, did not have access to psychological assessments or treatment.
- Staff received clinical supervision. However, it was provided less regularly than the trust's target.
- Staff did not always have sufficient knowledge of the Mental Health Act Code of Practice or Mental Capacity Act. Documentation was not always completed in line with these Acts.
- Staff were not always using systems in place to document and monitor when patients were taking Section 17 leave.

However:

- Patients received ongoing monitoring of their physical health needs. Wards employed registered general nurses who had improved the services ability to recognise patients' physical health concerns and respond accordingly.
- Medicines were well managed across the service. Wards received regular support from pharmacists who carried out audits and provided advice and training to staff.
- The service had recently introduced therapeutic staffing. This model integrated occupational therapists and psychologists into staff teams and provided patients with a wider range of structured activities seven days a week.
- Teams were made up of skilled staff who were supported by the trust to improve their profession development.

Summary of findings

- Staff had regular meetings and handovers where they discussed patients' care needs in detail.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with dignity and respect. Staff had a good understanding of patients' needs and listened to their views.
- The therapeutic staffing model provided recovery groups that encouraged patients to maintain their independence.
- The service was committed to involving families and carers.
- Patients had good access to advocacy support. They also had many forums where they could give feedback about the service.

However:

- Patients generally felt they were involved in planning of their care. However, staff did not always reflect this involvement in patients' care records.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The service had improved the way they planned for patients being discharged. They employed discharge facilitators to address issues preventing discharge. In the last six months the service had significantly reduced its use of private beds.
- The psychiatric intensive care unit, Willow Suite, employed two staff dedicated to assessing and managing referred patients. Patients were able to access this service with minor delays and staff were supported in the event of delays.
- Patients had access to a wide range of therapy rooms and activities. Since therapeutic staffing had started these activities were offered seven days a week. Patients had access to mobile phones and rooms to see visitors in private.
- The majority of wards had systems in place that allowed patients to access their rooms independently.
- All wards displayed a wide range of patient information. Patients could access interpreters and chaplains.
- Patients knew how to complain and staff knew how to manage complaints. Staff discussed complaints and acted on feedback.

However:

Summary of findings

- Patients had access to outside areas. However, they did not all contain seating areas and some access was restricted due to environmental risks.
- The trust's no smoking policy was presenting issues for patients and staff. These included episodes of physical aggression, inconsistencies in following the policy, and increased risks of patients smoking in bedrooms.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Some staff felt that senior managers were only visible when incidents occurred.
- Some managerial decisions had been counter-productive. These included salary incentives that excluded some staff; lack of clarity on wards providing same-sex guidance; and inconsistencies in following the no smoking policy.
- The majority of areas that the trust needed to make improvements in were related to governance systems.

However:

- Staff knew the trust's vision and values and agreed with them. Ward managers felt their teams incorporated these in their work and they considered them when interviewing for new staff.
- Ward managers had effective governance systems to enable them to monitor training, supervision and staffing levels.
- Staff had the use of effective systems to record incidents and safeguarding issues.
- Staff enjoyed their roles and morale was generally high. Staff felt supported by managers and colleagues and had opportunities for career progression.

Summary of findings

Information about the service

Kent and Medway NHS and Social Care Partnership Trust provides mental health, substance misuse, forensic and other specialist services for 1.7 million people in Kent and Medway across 50 sites.

The acute wards for adults of working age and psychiatric intensive care units provided by Kent and Medway NHS and Social Care Partnership Trust are part of the trust's acute service line.

Acute wards for adults of working age and psychiatric intensive care units are provided across three sites: Littlebrook Hospital in Dartford, Priority House in Maidstone and St Martins Hospital in Canterbury.

Littlebrook Hospital has three acute wards for adults of working age: Amberwood ward, Cherrywood ward and Pinewood ward. Amberwood ward and Cherrywood ward admit both men and women and both have 17 beds. Pinewood ward has 16 beds and admits women only. There is one psychiatric intensive care unit, called the Willow suite. It has 12 beds and admits both men and women.

Priority House has three acute wards for adults of working age: Chartwell ward, Boughton ward and Upnor ward. Chartwell ward admits women only, Boughton ward admits men only and Upnor ward admits both men and women. All three wards have 18 beds.

St Martins Hospital has four acute wards for adults of working age: Bluebell ward, Fern ward, Foxglove ward and Samphire ward. Bluebell ward and Foxglove ward admit both men and women and have 18 beds each. Samphire ward admits men only and has 15 beds. Fern ward admits women only and has 18 beds.

The Care Quality Commission inspected Kent and Medway NHS and Social Care Partnership Trust under its new methodology of inspection in March 2015. We rated the acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated the key questions of safe, effective, responsive and well-led as requires improvement with the key question of caring rated as good.

Following the inspection in March 2015, the Care Quality Commission informed the trust that:

- The trust must ensure it has a system to maintain the privacy and dignity of women who are secluded on Willow Suite (psychiatric intensive care unit (PICU).
- Trust managers must ensure that emergency equipment and medication are accessible and in date and ensure that effective systems are put in place for regularly checking emergency equipment and medication.
- The trust must put systems in place to ensure that, following incidents of aggressive behaviour or restraint, the care plans for the patients involved are updated to describe how to prevent, manage and de-escalate potential future incidents.
- Trust managers must ensure that the Mental Health Act is consistently implemented in accordance with the Code of Practice; and that staff working on the acute and PICU wards have sufficient understanding of the Mental Health Act and its Code of Practice to ensure patients are given correct information about their rights and to ensure medication is administered lawfully under the Act.
- Trust managers must ensure that delays in finding PICU beds for patients are minimised.
- The trust must ensure that its monitoring processes identify gaps and problems in the services, and identify the reasons behind such issues.

We also informed the trust that:

- The trust should review the seclusion room to ensure it is equipped in accordance with the Mental Health Act Code of Practice.
- The trust should make sure staff have access to a reliable emergency alarm system.
- The trust should ensure there are robust processes in place for assessing and managing environmental risks, and that these are followed.
- The trust should ensure there are adequate numbers of appropriately qualified and experienced staff.

Summary of findings

- The trust should ensure that all patients have a risk assessment which is reviewed regularly and updated in response to changes.
- The trust should ensure that staff understand the circumstances and limitations within which de-escalation rooms can be used to nurse patients who are violent or aggressive.
- The trust should ensure that all incidents of restraint are recorded correctly, and ensure any use of prone restraint is consistent with Department of Health guidelines.
- All patients should have care plans that are individualised, incorporate their views, and are recovery focused.
- All staff should have an understanding of the Mental Capacity Act and Deprivation of Liberty safeguards. .
- The trust should make suitable sleeping arrangements for patients who return from leave, and reduce the need for patients to change bedrooms for non-clinical reasons.

We issued the trust with six requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 HSCA (RA) Regulations 2014 - Person-centred care.
- Regulation 10 HSCA (RA) Regulations 2014 - Dignity and respect.
- Regulation 11 HSCA (RA) Regulations 2014 - Need for consent
- Regulation 15 HSCA (RA) Regulations 2014 - Premises and equipment.
- Regulation 17 HSCA (RA) Regulations 2014 - Good governance.

The Care Quality Commission also carried out a focussed inspection of the acute wards for adults of working age and psychiatric intensive care units at Littlebrook Hospital in July 2016. This was following concerns raised during a visit by a Mental Health Act reviewer and information we received through our intelligent monitoring programme.

Following this inspection the Care Quality Commission informed the trust that:

- The trust must ensure that the service is providing accommodation that adheres to guidance on same-sex accommodation.
- The trust must take action to ensure all patients have access to psychological assessment and interventions.
- The trust must ensure that all staff are able to identify safeguarding concerns and are competent in how to escalate them.
- The trust must ensure that the systems they use to alert safeguarding referral to the relevant agencies are working appropriately.

We also informed the trust that:

- The trust should ensure they stock all medicines recommended for environments that use restrictive practice.
- The trust should ensure the services seclusion facility supports patients in line with their seclusion policy.
- The trust should ensure that all areas within the ward environments are labelled correctly.
- The trust should have appropriate systems in place to ensure fridge temperatures are maintained at levels suitable for storing medicines safely.
- The trust should take action to ensure their provision of therapeutic activities is in line with targets recommended by the Commissioning for Quality and Innovation (CQUIN).
- The trust should review its approach to recording progress notes in patients care records.
- The trust should ensure that all staff have access to a local induction relevant to their working environment.
- The trust should have systems in place to ensure Mental Health Act documentation is completed correctly and accessible to staff.
- The trust should improve their systems in relation to patients accessing advocacy services.
- The trust should adopt a system which allows patients to access their bedrooms independently.
- The trust should ensure that outside areas accessible to patients offer comfort and therapeutic benefit.

Summary of findings

We issued the trust with four requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 HSCA (RA) Regulations 2014 - Person-centred care.
- Regulation 12 HSCA (RA) Regulations 2014 - Safe care and treatment.
- Regulation 13 HSCA (RA) Regulations 2014 - Safeguarding service users from abuse and improper treatment.

Our inspection team

The inspection team was led by:

Chair: Dr Geraldine Strathdee, CBE OBE MRCPsych National Clinical Lead, Mental Health Intelligence Network

Head of Inspection: Natasha Sloman, Head of Hospital Inspection (mental health), Care Quality Commission

Team Leader: Evan Humphries, Inspection Manager (mental health), Care Quality Commission

The team that inspected the acute wards for adults of working age and psychiatric intensive care units comprised two CQC inspectors, one CQC inspection manager, seven nurse specialist advisors, two medical specialist advisors, two occupational therapist specialist advisors, one psychologist specialist advisor and two experts by experience.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients, carers and staff at focus groups.

During the inspection visit, the inspection team:

- visited all eleven of the wards across three hospital sites and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 43 patients who were using the service and collected feedback from 13 patients using comment cards
- spoke with five carers of patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with the clinical quality and compliance lead for the service
- spoke with 93 other staff members; including doctors, nurses, occupational therapists, psychologists, pharmacists, health care assistants and pharmacists
- spoke with three clinical leads and two modern matrons with responsibility for these services
- attended and observed eleven hand-over meetings, four multidisciplinary meetings and three ward rounds
- looked at 67 treatment records of patients
- carried out a specific check of the medication management on all wards

Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We received feedback from 13 patients via comment cards. Of these, two were positive, 10 were negative and one was mixed. Positive comments were around caring and helpful staff, patients feeling they were treated with dignity and respect and safe and clean environment. Negative comments were around staff being abusive and poorly trained, patients' rights being breached, no access to personal possessions, activities hardly ever happening, poor communication with families and care not being patient-centred.

During our inspection, we spoke with 43 patients and five carers. We found this feedback to be more positive. Further positive themes were patients enjoying the range of activities and patients and carers being involved in their care.

Good practice

The service had recently introduced therapeutic staffing. This model integrated occupational therapists and psychologists into nursing staff teams and provided patients with a wider range of structured activities seven days a week. Senior management at St Martins Hospital were planning to research the model to see how it had impacted on issues such as patient satisfaction, levels of aggression and staff morale.

The service employed registered general nurses. They supported staff to ensure that daily monitoring of patients' physical health was completed and doctors were alerted to any changes. The service had received feedback from acute services and paramedics that the supporting physical health documentation that accompanied patients was significantly improved. The registered general nurses also supported other staff with training around physical health monitoring, taking an electrocardiogram and interpreting the results, physical health medicine and using and maintaining other physical health monitoring equipment.

The trust had used an external agency to support improvements in efficiency and clinical outcomes across the service. Their work had concentrated on improving discharge processes and increasing client contact time with the community teams. This system had been developed at St Martins Hospital and was now being used at Priority House and Littlebrook Hospital. Staff from St Martins Hospital were supporting the other sites to establish the model.

The service employed three workers across the acute mental health wards and 23 in total across the trust. Their role was running music groups, peer support groups and offering one to one sessions. They were full-time posts and workers had good links with their equivalents in community settings so were able to handover their work when patients were discharged.

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to improve

- The trust must ensure that the service is providing accommodation that adheres to guidance on same-sex accommodation.

Summary of findings

- The trust must ensure that all patients have risk assessments that are reviewed regularly and updated in response to changes.
- The trust must take action to ensure all patients have access to psychological assessment and interventions.
- The trust must ensure that all staff have sufficient understanding of the Mental Capacity Act and its guiding principles.
- The trust must ensure that systems in place to monitor patients using their Section 17 leave are used correctly.
- The trust must ensure that staff have completed mandatory training in line with their targets.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should look at ways to reduce the service's reliance on bank and agency staff.
- The trust should put systems in place to ensure that, following incidents of aggressive behaviour or restraint, the care plans for the patients involved are updated to describe how to prevent, manage and de-escalate potential future incidents.
- The trust should ensure staff are receiving regular supervision in line with its own targets.
- The trust should ensure that all patients have care plans that are individualised, incorporate their views and are recovery focused.
- The trust should ensure that documentation relating to patients being secluded is in line with their seclusion policy.
- Trust managers should ensure that the Mental Health Act is consistently implemented in accordance with the Code of Practice; and that staff working on the acute and PICU wards have sufficient understanding of the Mental Health Act and its Code of Practice to ensure patients are given correct information about their rights and to ensure medication is administered lawfully under the Act.
- The trust should ensure that Mental Health Act documentation is completed in line with the Code of Practice.
- The trust should ensure that outside areas accessible to patients offer comfort and therapeutic benefit.

Kent and Medway NHS and Social Care Partnership Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Amberwood Ward	Littlebrook Hospital
Cherrywood Ward	Littlebrook Hospital
Pinewood Ward	Littlebrook Hospital
Willow Suite (PICU)	Littlebrook Hospital
Boughton Ward	Priority House
Chartwell Ward	Priority House
Upnor Ward	Priority House
Bluebell Ward	St Martins Hospital
Fern Ward	St Martins Hospital
Foxglove Ward	St Martins Hospital
Samphire Ward	St Martins Hospital

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Qualified staff received training in the Mental Health Act Code of Practice. However, they told us the training did not provide comprehensive knowledge in all areas relevant to their roles. Non-qualified staff were not required to complete this training.

Documentation around consent to treatment was completed correctly and kept with patients' medicine charts.

Patients' leave requirements (section 17 leave) were up to date and accessible to staff. However, documentation did not provide sufficient detail regarding the exact conditions of the leave.

Detained patients across the service were read their rights on admission and regularly afterwards.

Staff at one of the hospital sites told us approved mental health professionals were sometimes delayed in attending the wards if patients need to be detained.

Mental Health Act administrators conducted mini audits of documents weekly. However, detailed audits that looked at the quality of documents did not happen regularly enough.

Patients on all wards had access to independent mental health advocates who were trained to work within the framework of the Mental Health Act and support people to understand their rights under the Act and participate in decisions about their care and treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received training in the Mental Capacity Act, its guiding principles and Deprivation of Liberty Safeguards. However, we found staff lacked knowledge and they told us that the ward consultants took a lead in this area.

Patients' capacity was discussed and reviewed but we found a variance in how this was recorded in progress notes and care plans. Within progress notes it stated whether or not patients had capacity, but lacked detail in how the decision had been reached.

Independent mental capacity advocates (IMCA) were available to patients, and how to contact them was clearly displayed on the wards.

We saw examples of a best interest meeting having taken place. Patient's family and an IMCA had been involved in these meeting.

The service did not have any patients subject to Deprivation of Liberty Safeguards at the time of the inspection.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The layout of all the wards meant there were blind spots at the ends of corridors and within some rooms. We observed staff regularly checking these areas and positioned themselves in areas where they could see down corridors. Pinewood ward had two bedrooms which were isolated in a corridor behind double doors. Patients who used rooms that had identified risks, such as wires in activity rooms or environment risks in bathrooms, were risk assessed prior to use and supervised by staff if necessary.
- Patients' bedrooms on Willow Suite contained multiple ligature risks. A ligature risk is an anchor point which patients can tie things from to assist self-harm. These included hinges on the door, taps and window and door handles. The service manager told us that Willow Suite had been due for refurbishment in April 2017, however, this work was now part of the 2018/2019 capital plans. Due to the concern with ligature risks, Willow Suite did not admit patients with a diagnosis of emotionally unstable personality disorder or as a high risk of self-harm. This meant they were nursed on the acute wards with increased management plans. We found ligature risks on the other wards in the form of door and window handles. We viewed ligature risk assessments and found that ligatures points had been identified and mitigated with management plans. We reviewed incidents reported and talked to staff on all three sites and found no evidence that patients were using anchor points to attach ligatures. Boughton ward had three anti-ligature point bedrooms that could be used for patients assessed as being at risk of self-harm. These had been introduced following an incident where a patient used a tap to attach a ligature.
- The vast majority of the wards complied with guidance on same-sex accommodation. Mixed-sex wards had clearly segregated corridors for male and female patients. On these wards, at St Martins Hospital and Priority House, patients had key fobs that allowed them access to their designated corridor as well as their individual rooms. At Littlebrook Hospital patient bedrooms had individual key fobs but the doors leading to the corridors did not. We were told that this had been requested and the trust had been given a quote for this work. The mixed-sex wards also provided female only lounges although we found these rooms at Littlebrook Hospital to be quite small with no access to a television.
- Willow Suite was a mixed-sex psychiatric intensive care unit (PICU) whose layout allowed same-sex guidance to be met if patient numbers were four and eight of either male or female. During our inspection, it was operating as an all-male ward and we were informed that this often happened depending on clinical need. Six female patients, who required PICU, were currently in private hospitals outside of the trust.
- We had concerns about the management of same-sex guidance on Cherrywood ward. The ward manager told us that in December 2016 the ward had become an all-male environment. However, this arrangement had been reversed after three weeks due to the need to accommodate female patients. The ward had been given little notice about this change and told us the uncertainty had been unsettling for patients and staff. Cherrywood ward's layout had two separate corridors which allowed same-sex guidance to be met if patient numbers were four and 13 of either male and female. However, during our inspection it was accommodating eight males and nine females, with four males and nine females sharing the 13 bed corridor. Three of the males were occupying rooms at the start of the corridor before a double door which was not securable. A further male was then occupying the assisted mobility room at the end of the corridor with nine females. The patient's poor mental state was causing him to be verbally aggressive to anyone who walked past his room. Female patients told us that they were finding the situation intimidating and that it was having an impact on their recovery. We attended the daily management meeting and the issue was not discussed or escalated. We also found that this patient's risk assessment and care plan did not adequately address the risks presented and care required. We bought this to the attention of the trust who agreed to transfer this patient to an all-male ward. They also informed us that Amberwood ward was changing from a mixed-sex ward to an all-male ward in

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

an initiative to adhere to same-sex guidance across the trust. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they must ensure that the service is providing accommodation that adheres to guidance on same-sex accommodation. Improvements had been made in this area but we remained concerned that guidance was still being breached on Cherrywood ward.

- All wards had fully equipped clinic rooms. All wards had access to resuscitation equipment and medicine to be used in the event of a medical emergency. We saw that this was checked daily by night shift workers, and kept either within the clinic room or nurses' office. Following our comprehensive inspection in March 2015 we told the trust they must ensure that emergency equipment and medicine are accessible and in date and ensure that effective systems are put in place for regularly checking emergency equipment and medication. We were assured the service were now managing this issue effectively. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should ensure they stock all medicines recommended for environments that use restrictive practice. The service did not stock all emergency medicines in line with guidance from the resuscitation council. However, they had undertaken a risk assessment that had led to that decision.
- The clinic room on Willow Suite did not have a door that opened at the top only. This meant that staff had to administer medicine whilst keeping the door unlocked. Staff told us they felt this was a safety issue and told us that patients had pushed their way into the clinic room on three occasions in the last year. A stable style door had been requested to enable staff to administer medicine from behind a locked door, however, the ward had not received information on when it would be installed. Patients and staff had complained about the cold temperature of the clinic room on Amberwood ward. They had been told by the estates department that this was due to the cold outside temperature.
- Staff had access to examination couches to allow them to carry out physical health interventions, such as electrocardiograms. These couches and equipment were generally kept in clinic rooms although Willow Suite had a separate examination room.
- We viewed the seclusion room on Willow Suite, the psychiatric intensive care unit at Littlebrook Hospital, and found a number of environmental issues. The room had no window to allow natural light, no system to allow easy two way communication and no clock to ensure patients maintained orientation to time. We also found a number of ligature risks in the bathroom. These included taps and the toilet flush handle. We raised these concerns to the trust and they responded promptly and agreed not to use the seclusion room until these issues had been resolved. We were told that refurbishment was due for completion by the end of February 2017 and in the meantime the lock had been removed to ensure it could not be used for the purpose of seclusion.
- Littlebrook Hospital had another seclusion room in their emergency care area, which was located in another part of the building but accessible by all four wards. This seclusion room allowed clear observation and had a two-way communication system and clock. Patients received natural light through non-opening windows and adjustable heating and air conditioning. Patients had access to en-suite toilet facilities with anti-ligature fittings. The emergency care area had its own resuscitation equipment, first aid kit and fridge. Staff had access to an office within this area. The trust told us they had completed a risk assessment for escorting Willow Suite patients to this seclusion room as part of their response to closing the ward facility.
- Priority House had access to a seclusion room that was clean with no safety issues. It had clear observation, a two-way communication system and a clock. There was natural light during the day, artificial lighting could be adjusted and temperature was controllable. It had an area for patients to lie down and en-suite washing facilities. It was near to Upnor ward but patients being brought to seclusion from Chartwell ward and Boughton ward had to be escorted through a public area which could compromise their privacy and dignity.
- Following our inspection in March 2015 we told the trust they should review the seclusion room to ensure it is equipped in accordance with the Mental Health Act Code of Practice. We were satisfied that all operational seclusions rooms now met these requirements.
- All 11 wards we visited had high levels of cleanliness and were well-maintained and all wards had dedicated

domestic staff. The patient led assessment of the care environment (PLACE) scores for cleanliness were 100% for Littlebrook Hospital and 99% for both St Martins Hospital and Priority House. The scores for condition, appearance and maintenance were 99%, 93% and 97% respectively. Boughton ward and Chartwell ward were located in older buildings and had refurbishments planned for April 2017. Amberwood ward and Cherrywood ward had been decorated and refurbished with new furniture in August 2015. During our inspection we saw domestic staff present on all wards. We spoke to these staff at all three sites and found they had appropriate inductions that prepared them for working in psychiatric environments. They all received training in infection control and control of substances hazardous to health. They had detailed cleaning schedules and we found cleaning records were kept and up to date.

- Staff had access to hand washing equipment throughout the wards and we saw that the majority of staff carried hand cleaning gel on their persons. We observed an isolated incident at St Martins Hospital whereby a member of staff disposed of some dirty towels appropriately but continued to wear the glove and proceeded to touch door handles.
- All wards had appropriate systems in place that ensured the environment was regularly checked for maintenance issues. All sites were able to escalate maintenance issues to the trust's estate department. Patients and staff told us that minor issues, such as lights not working, were responded to quickly. However, some issues such as water temperature and leaking showers took longer to be addressed. Following our comprehensive inspection in March 2015 we told the trust they should ensure there are robust processes in place for assessing and managing environmental risks, and that these were followed. We found this issue had been sufficiently resolved. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should ensure that all areas within the ward environments were labelled correctly. We found these issues had been fully addressed.
- Staff on all wards carried personal alarms that were signed for when received and returned. We were offered personal alarms on all sites we inspected and saw staff using the system correctly. Staff told us that visitors were routinely offered personal alarms when they entered the ward. Nurse call alarms were located around all wards, including patients' bedrooms. Following our comprehensive inspection in March 2015 we told the trust they should make sure staff have access to a reliable emergency alarm system. We saw that sufficient improvements had been made in this area.

Safe staffing

- All wards operated on the same staff shift pattern which was 6.50am – 2.40pm; 1.30pm – 9.20pm; and 8.50pm – 7.20am. Staffing levels on Willow Suite, the trust's psychiatric intensive care unit, were seven on both the early and late shift and five on the night shift. Staffing levels on the acute wards were six on both the early and late shift and four on the night shift. An additional member of staff worked between 8.00am – 4.00pm and 4.00pm – 12.00am. The ward manager was able to increase staffing levels in response to issues such as patients being on increased observation levels.
- All wards had staffing vacancies. The ward managers at Littlebrook Hospital and Priority House told us they had ongoing difficulties around recruiting regular staff. The trust had recently introduced staff incentives, such as increasing salaries to match that of NHS trusts nearer to London. However, we were told this increase only related to nursing staff and not allied health professionals, such as occupational therapists and psychologists. Ward managers at Littlebrook Hospital told us that staff had left the trust due to this and they were having difficulties recruiting the right staff mix to allow therapeutic staffing to be successful.
- We received data from the trust around staffing levels between 1 January 2016 and 31 December 2016 and found that; less than 2% of all shifts had not been filled at Littlebrook Hospital; less than 1% of all shifts had not been filled at Priority House; and hardly any shifts had not been filled at St Martins Hospital. Ward managers told us there was a heavy reliance on bank and agency staff, particularly at Littlebrook Hospital and Priority House. Between the same period 48% and 42% of all shifts, at these sites respectively, had been filled by bank or agency staff, with the figure for St Martins Hospital being 19%. The trust recognised this was an issue and told us about initiatives they had introduced to tackle this . These included identifying student nurses who were about to qualify and fast tracking their recruitment process and writing to all regular bank and agency staff

to highlight the benefits of being employed by the NHS. Most bank and agency workers were familiar to the wards they worked on and knew the patients well. Some had been given short term contracts which enabled them to access training and the trust's electronic care records system.

- All three sites had daily meetings where staffing levels were discussed. If extra staff were needed for issues such as patients requiring increased levels of observation, this was agreed by senior managers at this meeting. The meeting also monitored that all wards had enough staff trained in restraint and, if not, staff were moved between wards to ensure safe staffing levels throughout the service.
- Following our comprehensive inspection in March 2015 we told the trust they should ensure there were adequate numbers of appropriately qualified and experienced staff on the wards. Systems had been put in place to ensure this issue did not affect patient and staff safety. However, we felt that further improvements could still be made.
- Across the service, we observed a high presence of staff in communal areas. We observed staff to be engaging patients in conversation and activities. Staff did not remain in the nursing office unless they were occupied with care related tasks. Overall, our inspection team across the three sites felt that staff and patients displayed a positive relationship with each other.
- The wards daily therapeutic planner allocated times when staff could provide patients with one to one sessions. Staff and patients both confirmed that the introduction of therapeutic staffing had increased patient and staff interactions and during our inspection we found this to be evident. Willow Suite had not introduced therapeutic staffing but had protected time once a week where staff could offer patients one to one sessions.
- The vast majority of patients we spoke with told us that ward activities were rarely cancelled and that escorted leave was always provided even if there were short delays due to staff being unavailable. Two patients at Littlebrook Hospital felt that activities were cancelled regularly and attributed this to occupational therapists being needed for other tasks, such as observing patients who required extra support. They also told us they had experienced delays of up to three hours to get their escorted leave.
- All wards had enough staff to safely manage situations such as when a patient required restraining. All staff received training in prevention and management of violence and aggression to support them to safely restrain patients. The staff rota on Willow Suite, the psychiatric intensive care unit, was checked daily to ensure at least three staff, who were trained in prevention and management of violence and aggression, were on the ward at all times.
- All wards had full-time consultant psychiatrists. They were supported by staff grade doctors, who worked between two and four days a week and junior doctors on their placement in mental health settings. Medical staff told us that the wards would benefit from having full-time staff grade doctors on all wards. Junior doctors at Littlebrook Hospital told us the on call rota was now covered by one junior doctor where previously it had been two. They expressed concerns around responding to emergency situations if they were off site. Upnor ward did not have access to a junior doctor one day a week and this could lead to delays in physical health assessments being carried out for newly admitted patients. Some junior doctors expressed concern about medical cover. We raised a particular concern around this to the trust who responded and put in place additional support on one ward where senior medical cover to support junior doctors needed to be improved.
- Staff were expected to complete mandatory training to prepare them for their roles. There were 30 training courses in total although staff with certain responsibilities only required some courses. Mandatory training included clinical risk assessment, immediate life support, Mental Health Act and Mental Capacity Act, prevention and management of violence and aggression and safeguarding children and adults. Mandatory training completion rates varied between 93%, on Bluebell ward and Fern ward, and 86% on Boughton ward. However, we found safeguarding adults level two training, that was required for qualified staff, to be consistently low across the wards at Priority House and St Martins Hospital (between 31% and 62%). We found safeguarding children level three training, that was required for qualified staff, to be consistently low

across the wards at St Martins (between 42% and 50%). The trust told us that the expectation for qualified staff to complete this level of training had been introduced recently and recognised that some staff had been unable to access it. We also found that levels of immediate life support training were low on Chartwell ward (50%) and Cherrywood ward (33%). Some staff told us that the training provided through e-learning did not ensure they gained sufficient learning outcomes as it was possible to bypass the learning content and just do the quiz at the end.

Assessing and managing risk to patients and staff

- Between 1 October 2016 and 13 January 2017 there were 58 episodes of patients being secluded across the service. There were 29 episodes on Willow Suite. The other 29 episodes happened on the six acute wards at Littlebrook Hospital and Priority House with the highest being 10 on Amberwood ward.
- Between the same period there were 19 episodes of patients being supported in long term segregation. Eighteen of these episodes occurred at Littlebrook Hospital, with one isolated incident at Priority House. Willow Suite (PICU) reported the highest amount with eight episodes.
- During the same period there were 268 episodes of patients being restrained across the service. The wards with the highest occurrences of using restraint on patients were Bluebell ward and Amberwood ward, each reporting 40 episodes. Of these restraints, 16 were reported to have been in the prone position. This is when a patient is restrained faced down. Staff told us these incidents were rare since they had been trained to restrain people on their side when administering medicine via intramuscular injection. All prone positioning now occurred if patients naturally put themselves, or fell, into that position before staff had the opportunity to reposition them onto their side or back.
- We reviewed 67 care records of patients across the service. All patients had a current risk assessment with 48 of these being detailed. Of the other 14, that we deemed to be lacking detail, five of these were for patients at Chartwell ward where we looked at seven care records. Examples of this were a pregnant patient not having the risk presented by certain medicines identified in their risk assessment and a patient not having their risk of aggression to other patients and family members identified in their risk assessment. We reviewed the risk assessment for a patient at Priority House who had mobility issues and found that an assessment around their risk of falling had not been completed. We also reviewed the care records for a patient at Priority House who had Hepatitis C and found there was no risk assessment around the management of infection control issues. We found 22 care records that contained risk assessments that were not regularly reviewed or updated after incidents. This issue related to eight out of 20 care records at Littlebrook Hospital; 13 out of 22 care records at Priority House; and one out of 25 care records at St Martins Hospital. Following our comprehensive inspection in March 2015 we told the trust they should ensure that all patients have a risk assessment which is reviewed regularly and updated in response to changes. We found this was still an issue at Littlebrook Hospital and Priority House.
- Patients were not allowed access to phone chargers. Phones had to be charged in the nurses' office. Patients were allowed to use their phones but had to sign a disclaimer to not use the camera function. Staff were also being vigilant around patients access to plastic bags and were reminding visitors to take them with them with they left the ward.
- The service was monitoring patients' access to lighters due to incidents of patients smoking in their bedrooms. We observed staff handing out lighters and asking them to be returned when patients left and returned to the ward. The signing in and out book had a space for this to be recorded but we found the use of this to be inconsistent across all three sites.
- Informal patients were required to ask staff if they wanted to leave as all wards were locked. There were signs explaining this on entrances to all wards. Staff signed informal patients in and out and recorded times and what they were wearing. Staff told us they would do brief risk assessments on all patients before they left the ward.
- The service used four levels of observation. These were general one hour checks; intermittent checks four times an hour; close observations within eyesight; and close observations within arm's length. We checked observation records across all three sites and saw that staff were maintaining appropriate levels of observation

on all patients. Patients were routinely placed on intermittent observations for up to the 72 hours after admission. We heard observation levels being discussed and reviewed in all handovers.

- Staff told us that they would ask patients to empty their bags and pockets when they returned from leave to ensure they were not bringing restricted items onto the ward, such as lighters and alcohol. Some staff across all three sites were unsure what the search policy was around physically searching people but told us that magnetic wands were available if they were concerned patients may be carrying weapons. Staff were aware that bedroom searches should be conducted with two staff present.
- Staff told us incidents of restraint had significantly decreased since the introduction of therapeutic staffing. They felt being more engaged with patients made talking to them when they were distressed or agitated much easier. Most wards had calming rooms, with the exception of Boughton ward and Chartwell ward, where staff could spend time with agitated patients without impacting others. We saw these rooms being used many times on wards at Littlebrook Hospital and St Martins Hospital. Staff were seen staying with patients in the room and only closing the door to protect the patient's dignity. The doors of these rooms could not be locked and patients could leave at any time. Patients at Priority House could access calming boxes which contained cards with mindfulness prompts and activities to offer distraction. Following our comprehensive inspection in March 2015 we told the trust they should ensure that staff understand the circumstances and limitations within which de-escalation rooms can be used to nurse patients who are violent or aggressive. This was no longer a concern. .
- The trust had recently trained staff in restraining patients on their side if they needed to be administered intramuscular injections to help them calm down. This had eliminated the need to restrain patients in a face down position. A patient from Littlebrook Hospital told us that they had been restrained and carried to the seclusion room, which was outside the ward. We were also informed, through our intelligent monitoring system, of a similar incident happening at Priority House a few days prior to our inspection. Following our comprehensive inspection in March 2015 we told the trust they should ensure that all incidents of restraint are recorded correctly, and ensure any use of prone restraint is consistent with Department of Health guidelines. We found this was no longer an concern. .
- Patients who were administered rapid tranquilisation injections had their physical health monitored in accordance with the National Institute for Health and Care Excellence guidance. We found one incidence at Priority House, where a patient had been refusing physical health monitoring,that had not been recorded sufficiently in their care records. We spoke to staff about this who agreed they would use this example as a learning experience for the team.
- We reviewed 11 seclusion records from the two week period prior to our inspection. We found two occasions where the medical review had been delayed. This meant that patients may have remained in seclusion longer than required. We also found some inconsistencies in the following areas, staff recording the room's temperature, staff not always completing observation records and crossing out of information and difficult to read handwriting. The trust's seclusion policy stated that after every incident of seclusion a post incident review form and a patient debriefing form should be completed. This was not always happening and this further meant that not all incidents of seclusion were reported as an incident on the trust's incident reporting system. Following our focussed inspection of Littlebrook Hospital we told the trust they should ensure the services seclusion facility supports patients in line with their seclusion policy. This remained a concern.
- Staff across all wards had a sound understanding of safeguarding issues and were aware of processes to be followed to make safeguarding alerts. All safeguarding referrals were investigated by a senior member of staff who had received additional safeguarding training from the local authority. However, we found levels of advanced mandatory safeguarding training for qualified staff to be below the trust's target of 85%. In all handovers we attended we heard staff giving updates on current safeguarding issues and discussing potential safeguarding referrals. Patient safeguarding was one of the 10 factors that was considered when planning discharge from the ward. Staff at St Martins Hospital were supported by the local authority safeguarding lead who worked on the hospital site. They found this

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

individual approachable for general advice on safeguarding issues. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they must ensure that all staff are able to identify safeguarding concerns and are competent in how to escalate them and they must ensure that the systems they use to alert safeguarding referral to the relevant agencies are working appropriately. We found significant improvements in both of these areas.

- We observed appropriate medicines management on all wards. Drug cupboards were secure and controlled drugs were stored and administered correctly. We found one incident on Fern ward where a controlled drug had not been signed for by two members of staff. We reviewed all the medication charts on all wards and found five occasions, across Littlebrook Hospital and St Martins Hospital, where patients had been prescribed medicine 'as required' for more than two weeks without it being reviewed. This meant that doctors had not made a decision as to whether the medicine should be prescribed regularly, if the patient was using often, or stopped, if the patient was not using it. Staff monitored the temperature of fridges that were used to store medicine daily to ensure they were safe to use. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should have appropriate systems in place to ensure fridge temperatures are maintained at levels suitable for storing medicines safely. This issue was now resolved.
- Patients had their photo attached to their medicine chart or it was recorded that they had refused their photo being taken. In these instances patients were given wrist bands to wear to confirm their identity. This practice ensured that staff administered medicine to the correct patient.
- Patients on all three sites had access to rooms where they could see children. These rooms were situated outside the wards in reception areas.

Track record on safety

- Between 1 September 2015 and 31 August 2016 the service reported 18 serious incidents reported through the trust's incident reporting system. The highest number of incidents recorded was in the category of allegations or incidents of physical abuse and sexual assault or abuse, with eight (44%).
- The service reported 22 serious incidents on NHS England's serious incident management system during the same period which accounted for 13% of the trust total. The category 'disruptive/ aggressive/ violent behaviour' meeting the serious incident criteria had the highest number of related incidents with eight. Amberwood ward had the highest number of serious incidents with four (22%), followed by Foxglove ward with three (17%).
- A member of staff from Littlebrook Hospital informed us of an incident whereby a patient had died after a cardiac arrest. The investigation found that an electrocardiogram had not been carried out due to the patient being disturbed on admission and refusing the intervention. Lessons learnt had been the importance of revisiting uncompleted actions. In response, the trust had introduced a handover book for junior doctors to record actions that needed following up by the next doctor on duty.
- Littlebrook Hospital had restricted access to boiling water following an incident whereby a patient threw boiling water at another patient on Amberwood ward. Hot water was now provided in flasks at a temperature below boiling.
- We were told that an incident involving a patient, in Priority House, using a tap in their bedroom as a ligature had led to three rooms being made anti-ligature areas to support patients assessed as high risk of self-harm. One of the wards on this site had also introduced a form that staff needed to sign to confirm they had attended handover. This followed an incident whereby staff let an informal patient leave the ward as they were not aware of current risks that had been discussed in handover. They also made the system used to open the front door more secure to mitigate against the risk of patients absconding.
- An incident at Priority House whereby an agency domestic staff gave their phone number to a patient led to these staff members being given a proper induction before starting work on the wards.

Reporting incidents and learning from when things go wrong

- All staff were able to record incidents on the trust's electronic incident reporting system. Ward managers then received an automated email to alert them to the

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incident. They reviewed the incident and gave it a rating before it was sent to senior management who monitored incidents for the purpose of learning opportunities. Wards displayed risk awareness information and security alerts on staff noticeboards.

- Staff we spoke with had a sound understanding of what should be reported as an incident. They were aware that issues such as self-harm, medicine errors, physical assault and patient restraint should all be reported. We viewed recent incidents that had been reported at St Martins Hospital and found examples of appropriate incidents being reported. However, we found staff across the service had a high threshold of tolerance regarding verbal abuse. Staff said they would only report this as an incident if it was excessively threatening or racial in content.
- We saw an example of staff on Bluebell ward fulfilling the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify people (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. A patient had been informed that their regular medicine was out of stock and was given a prescribed alternative. Staff then found the medicine and approached the patient to inform them but they were asleep. Staff recorded this in the patient's care records with a plan to inform them in the morning. We spoke to the patient who confirmed they received a full explanation of the incident and were given the opportunity to ask questions. Patients told us that staff would offer them support after incidents, however, when we checked patient's care records we found these conversations were not always recorded.
- St. Martins Hospital and Littlebrook Hospital had a police liaison officer who was available to discuss more serious incidents, such as patient on patient and patient on staff assaults. We were told that their intervention had recently led to a patient being charged after assaulting a member of staff. Staff told us the police liaison officer had given them confidence that assaults would be taken seriously. They also felt that the outcome of this incident would have circulated amongst patients through social media and would act to further decrease serious assaults.
- Staff told us they felt supported by the trust, managers and colleagues after incidents. We saw minutes of staff meetings across the service and saw that incidents were routinely discussed. We also heard incidents being discussed during handovers and multidisciplinary meetings. Clinical psychologists provided debriefing after serious incidents at St. Martins Hospital and Priority House. At Littlebrook Hospital debriefs were led by the wards' consultant psychiatrists.

Are services effective?

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Our findings

Assessment of needs and planning of care

- We reviewed 67 patients' care records across the service. All contained comprehensive patient assessments, which included presenting situation, assessment of mental state and social situation including consideration of any children who were affected by the admission. These assessments were completed prior to admission by staff from the crisis teams, however, we saw that staff and junior doctors clarified this information on admission.
- All but seven care records showed that patients had a physical health check on admission. Six of these were for patients at Priority House and one at St Martins Hospital. These were carried out by either the wards registered general nurse (RGN) or the junior doctor. The ongoing monitoring of physical health issues was of a high standard. The introduction of RGNs on the ward meant that physical health concerns were identified promptly. All patients had their temperature, blood pressure, heart rate and breathing regularity observed daily. Patients also received electrocardiograms and blood monitoring on admission and when required. Chartwell ward had yet to employ an RGN and only had access to one from a neighbouring ward once a week. This meant ongoing physical health monitoring was not maintained. An example of this was insufficient monitoring of a patient, who was refusing support, with an open wound who had hepatitis C. We discussed this with the trust who responded by having the patient reviewed by the senior physical health nurse to ensure their care plans and risk assessment reflected their needs and managed any associated risks regarding blood borne viruses.
- We reviewed 67 patients' care plans across the service. The service had changed their approach on how staff approached care planning with patients as this had been identified as an area the trust should improve on following our comprehensive inspection in March 2015. The trust had identified five domains that patients should have their care planned around. These were safety and recovery, mental health, physical health, support networks, and discharge planning. Staff and patients on all sites had access to pocket sized guidance on how to work together in order to produce effective person centred care plans. All patients had care plans, with the exception of one patient on Foxglove ward who had been admitted the previous day. Patients care plans were regularly reviewed and updated in 45 cases and partially reviewed and updated in 20 cases. Two patients at Priority House had care plans that had not been reviewed since their admission. We found a variance in how staff supported patients to produce care plans that were person-centred, addressed a full range of needs and were recovery focussed, across all three sites. At St Martins Hospital we found 21 out of 25 care plans addressed these areas to a high standard with the only issues being that four care plans could have been more recovery focussed. Care plans on Samphire ward and Fern ward were good in all areas. The ward manager from Fern ward had been involved in a pilot study to improve care plans 18 months ago and had looked at this area as part of his leadership course. At Priority House we found the majority of care plans,15 out of 22, addressed a full range of patient needs but found that patient views and a focus on recovery was not regularly contained in care plans. We also found that issues, such as smoking needs, physical health and management of aggression were not often addressed. At Littlebrook Hospital care plans were of an overall good standard, with the exception being Willow Suite where we found all five care plans were not recovery focussed. Following our comprehensive inspection in March 2015 we told the trust that systems must be put in place to ensure that, following incidents of aggressive behaviour or restraint, the care plans for the patients involved are updated to describe how to prevent, manage and de-escalate potential future incidents and that all patients should have care plans that are individualised, incorporate their views, and are recovery focused. We saw that improvements had been made in this area but felt that further improvements were needed.
- Patients' progress notes within care records were sufficiently detailed to allow colleagues to understand patients' ongoing plan of care. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should review its approach to recording progress notes in patients care records. This was no longer a concern..
- Staff accessed information they required to deliver care through the trust's electronic patient record system. All

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regular staff had individual login cards to maintain confidentiality. This system enabled staff to upload paper documents, such as Mental Health Act documentation, to patient's individual care record. Staff received training in the use of the system as part of their trust induction. However, the system was regularly updated with new functions, such as a different way of recording patients' care plans, and we spoke to some staff who felt they would benefit in extra training in these areas. Bank and agency staff across the service did not have passwords to access or upload data onto the system unless they were offered short term contracts. This put pressure on regular staff to update patients' care records on their behalf.

Best practice in treatment and care

- We reviewed 128 medicine charts across all 11 wards and found that medical staff followed appropriate prescribing guidance. Two patients on Willow Suite were prescribed antipsychotic medicines in a higher dose than recommended by the British National Formulary, the pharmaceutical reference book used in the United Kingdom. We checked these patients care records and saw these doses had been reviewed appropriately by the ward consultant.
- The service had recently introduced therapeutic staffing across all 10 acute inpatient wards. This meant that allied health professionals, such as occupational therapists and psychology assistants, were included in staffing numbers. We were told that the concept had originated due to the difficulties in recruiting qualified nursing staff and had developed into a therapeutic model that provided a recovery focussed approach for patients. Occupational therapy staff told us they had benefitted from this model in a number of ways. These included being able to coordinate shifts, admit and discharge patients, and being able to make decisions on issues such as ending periods of seclusion. On the negative side they felt that when the wards had many patients on increased levels of observations this could lead to activities being cancelled. Patients we spoke with felt that the level of activity on the wards was varied and beneficial to their recovery. We observed 'start of day meetings' that happened every morning, including weekends, and saw that patients were given flexibility around the activities offered. We looked at activities on offer across the service and saw they addressed issues such as fitness and exercise, relaxation, recovery and creativity. We spoke to the acute service matron and clinical service manager at St Martins Hospital where the model had been introduced. They were planning to research the model to see how it had impacted on issues such as patient satisfaction, levels of aggression and staff morale. Littlebrook Hospital were experiencing some issues with the model due to having difficulties recruiting occupational therapy and psychology staff. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should take action to ensure their provision of therapeutic activities is in line with targets recommended by the Commissioning for Quality and Innovation (CQUIN). We found significant improvements had been made in this area and it was no longer a concern. .
- Patients at St Martins Hospital and Priority House had access to psychological therapies. Both sites had clinical psychologists who led teams of psychologists and assistants. Patients at Littlebrook Hospital had a lack of psychological input. The service manager told us they were constantly advertising psychology posts but had difficulties recruiting into them. They currently had vacancies for a band seven clinical psychologist and two band four assistant psychologists. We spoke with the senior clinical psychologist at Littlebrook Hospital who was currently covering two wards due to vacancies. They were able to offer between two or three patients two sessions a week to address issues such as coping with low mood or relapse prevention. The psychology assistants completed an initial screening of patients' psychological needs to determine which patients would be offered these sessions. However, psychological based groups were offered to patients as part of the therapeutic day. These included a hearing voices group and a goal setting group. Willow Suite currently did not employ any psychologists. They were advertising for these positions in preparation for introducing therapeutic staffing. We were told that patients could be referred for psychology within Littlebrook Hospital but could not find any evidence of referrals being made. The ward manager could only recall one referral being made to psychology in the last year. Following our focussed inspection of Littlebrook Hospital in July 2016 we told

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the trust they must take action to ensure all patients have access to psychological assessment and interventions. This issue had not been sufficiently resolved.

- Patients' physical health care needs were well monitored by all wards. The service had recently employed a registered general nurse (RGN) to all wards. Chartwell ward had not recruited into this post yet and this was having an impact on patients' physical health needs. We spoke with RGNs on five wards and found them to be competent and committed. They monitored patients' physical health daily and alerted doctors to any changes. We heard an example of a RGN administering oxygen and calling an ambulance after identifying a patient going into sceptic shock. The service spoke of the positive impact the RGNs had bought to the service and how they had enhanced the service's reputation when liaising with local acute hospitals and paramedic services. They had received feedback, from these services, that the supporting physical health documentation that accompanied patients was accurate and beneficial. The RGNs also supported other staff with training around physical health monitoring, taking an electrocardiogram and interpreting the results, physical health medicine and using and maintaining other physical health monitoring equipment.
- Staff told us that if patients' physical health needs required specialist care this would be addressed. We saw an example of this on Foxglove ward. A patient had been admitted and staff were concerned by their physical health presentation and recent history. The patient was immediately transferred to a general hospital and the ward was providing psychiatric support, with a psychiatric nurse being present at all times. The ward had raised a safeguarding alert as they were concerned these physical health concerns had not been recognised by the patient's community setting.
- The service used a recognised rating scale called mental health clustering to assess and record the severity of patients' mental health issues. This was done routinely on admission to the ward with the expectation that this was repeated by the receiving team on discharge from the ward.
- Staff participated in a number of audits. These included auditing care plans, adherence to medicine management and physical health metrics such as assessments of nutritional needs. The service was adhering to the current Commissioning for Quality and Innovation standard of assessing, documenting and acting on cardiometabolic risk factors in patients with psychosis. They were monitoring the following cardiometabolic parameters, smoking status; lifestyle (alcohol and drugs); body mass index; blood pressure; glucose regulation and blood lipids. Medical staff told us they had recently audited the use of rapid tranquilisation against national standards and the physical health monitoring of patients after rapid tranquilisation.

Skilled staff to deliver care

- The service employed mental health nurses, occupational therapists and psychologists as the core staff involved in the therapeutic staffing model. We found some areas of the trust had difficulties in recruiting certain disciplines. However, all staff we spoke with had access to senior clinical leaders from their discipline. The different disciplines had regular meetings on all three sites which supported them to maintain their professional identity.
- The service had recently enrolled registered general nurses on all of the acute wards to support patients' physical health needs.
- We spoke with pharmacists who were available to all wards and visited a number of times a week. They offered robust support in a number of areas; they delivered staff training in areas such as smoking cessation and physical health medicines; carried out regular stock check and liaised with the external pharmacy used by the trust to ensure that overstocking of medicine was not an issue. They also offered one to one sessions to patients to discuss issues around their medicine and carried out a number of audits in collaboration with ward managers. These included monitoring medicine charts for missing signatures, monitoring if open dates for liquids and creams were recorded, whether medicine packets containing patient names were disposed of in a way that maintained confidentiality and that discharged patients' medicine was disposed of correctly. We saw that outcomes of these audits were shared with staff in team meetings to ensure they remained mindful of good medicine management. We found some isolated incidences on

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Requires improvement

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wards at St. Martins Hospital where staff had been reminded to sign medicine charts after administering medicines. This meant they relied on memory as to whether the patient had taken the medicine, refused the medicine or not taken the medicine due to being off the ward or sleeping. These incidents were not recorded as incidents and were not captured by the pharmacist audits. Ward managers told us that staff were regularly told to use the appropriate symbols when dispensing medicine.

- All wards employed releasing time to care assistants. Their role was to support the staff team with administration issues such as orientating patients to the ward on admission, updating the whiteboards to reflect where patients were in terms of discharge planning, and supporting clinical staff with collecting data for audits. All unqualified staff were expected to complete the care certificate standards. These are standards that should be covered as part of induction training of new health and social care workers. We saw that staffs adherence to this was monitored through supervision.
- Staff received an appropriate induction that familiarised them to their place of work and prepared them for their roles. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should ensure that all staff have access to a local induction relevant to their working environment. We found this was no longer a concern.
- We spoke with a peer support worker based at Littlebrook Hospital. They felt the trust was a firm believer in the benefits of peer support and employed three workers across the acute inpatients wards and 23 in total across the trust. Their role was running music groups, peer support groups and offering one to one sessions. It was a full-time post and they found it enjoyable and rewarding. They had good links with peer support workers in community settings so were able to handover their work when patients were discharged.
- All wards had supervision systems that ensured all staff were allocated an appropriate supervisor dependent on their discipline and level of qualification. The trust informed us they expected all staff to receive clinical supervision monthly. However, between 1 October 2015 and 31 September 2016, the average monthly staff supervision rates across the service was 20%. Pinewood ward recording the lowest average rate of 2% and Fern ward achieved the highest rate with 42%. Regularity of clinical supervision had increased within the three months prior to our inspection and this included 71% of Pinewood ward staff, 90% of Foxglove ward staff, and 63% of Cherrywood ward staff receiving clinical supervision in December 2016. Staff told us they received supervision but confirmed it was not regular. We reviewed the quality of supervision records at St Martins Hospital and found it was detailed and addressed appropriate domains, such as caseload management, training needs and work life balance. The ward manager on Foxglove ward produced a bi-monthly handout for staff around current themes for staff to use as reference when giving and receiving supervision.
- Staff received annual appraisals to monitor their performance and discuss their career progression. We saw that 75% of staff, across the service, had received an appraisal within the last year. Bluebell ward had the highest appraisal rate, with 100%, whilst Cherrywood ward had the lowest at 48%. The trust had a 90% target for appraisals.
- Littlebrook Hospital staff were able to access support from two specialist personality disorder nurses who worked for the Medway crisis team. They were also able to get advice for supporting people with autism from a learning disability nurses from Amberwood ward.
- Ward managers had access to leadership training. The ward manager on Fern ward had completed the six month Mary Seacole leadership development programme designed by the NHS Leadership Academy. Health care assistants told us that the trust had stopped funding them to complete their nursing training. However, the trust supported them to progress to associate practitioners which was a career progression.
- Staff told us they had access to specialist training. These included being trained to take bloods, training in how to investigate incidents for the purpose of learning and training in working with families and carers. The service had a good approach to identifying champions to take the lead in specific clinical areas.
- A consultant working at Priority House was the trust's lead for electro-convulsive therapy. This is a treatment

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for severe depression which is administered through a controlled current of electricity through the brain which causes a seizure or fit. They had recently received accreditation through the Royal College of Psychiatrists.

- Ward managers felt they had good systems in place, and support from human resources, to manage poor performance. We heard examples of staff being supported with issues such as Mental Health Act knowledge and medicine administration by their ward managers or supervisors.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings happened three times a week on all wards. We observed these on all three sites and found all patients were discussed in detail. The multidisciplinary meeting on Foxglove ward was guided by a system called Meridian which identified 10 areas that affected patients' recovery. We observed that staff briefly discussed whether there had been any significant changes in the patient's presentation and then focussed on areas that had been identified as affecting their recovery. St. Martins Hospital's acute service manager and modern matron told us that the trust had used an external agency (Meridian) to support improvements in efficiency and clinical outcomes across the service. Their work had concentrated on improving discharge processes and increasing client contact time with the community teams. This system was also used at Priority House and Littlebrook Hospital but was not as embedded. Senior staff and ward managers from St. Martins Hospital had recently offered support to these sites in using the system through presentations and inviting staff to observe them using the system in practice.
- We observed staff handovers on most of the wards. We saw that all patients were discussed in detail and staff were engaged and contributed. Staff told us that therapeutic staffing and the registered general nurse (RGN) had benefitted handovers by making them more multidisciplinary. An example of this was the RGN on Willow Suite discussing the referral needs for a diabetic patient who was developing an ulcer on their foot.
- Staff across all sites told us that crisis team staff attended the wards regularly to discuss and assess patients who may be able to go home with their support. Patients' care coordinators attended review meetings. All sites had technology for people involved in patients care to attend meetings via conference calls.

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

- Staff received training in the Mental Health Act and its Code of Practice. All wards had had achieved a completion rate of above 85% with eight of the wards achieving 100%. However, the training was only required to be done once and staff told us that the training was not very detailed. The data we received from the trust suggested that only qualified staff required to complete this training.
- Mental Health Act documentation to certify whether a detained patient had consented to treatment or to certify that a patient did not consent, or lacked capacity to consent, to treatment were available and completed correctly. They were attached to patients' medicine charts or kept in a folder within the clinic room.
- We reviewed how section 17 leave was recorded and monitored across all sites. Section 17 of the Mental Health Act allows the responsible clinician (RC) to grant a detained patient leave of absence from hospital. We reviewed 51 records across the service and found some recurrent issues. The form did not make it clear where the RC should sign and how long the leave granted was valid for. The forms did not clearly describe the conditions of the leave and just recorded that it should be at nurses' discretion. Times when leave could be taken was not always specified, for example whether patients could use their leave in daylight hours or overnight. We also found that the forms were rarely signed by the patient or that a copy had been given to them or other relevant parties, such as relatives who patients were using their leave to visit. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should have systems in place to ensure Mental Health Act documentation is completed correctly and accessible to staff. Documentation was accessible to staff but felt that further improvements could be made in terms of documentation being completed correctly.
- We looked at the system that the sites used to record when patients left and returned from their leave. For

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seven patients at Littlebrook Hospital, who between them had used 88 episodes of leave, 34 had not been either signed or had time recorded. This meant it would be difficult for staff to identify when patients were absent outside of their allocated leave and could have an impact on the patient being unsafe in the community. We found the system was being used accurately at Priority House and St Martins Hospital.

- Detained patients across the service were read their rights on admission and regularly afterwards. The trust's policy was that patients on Section 2 should be reminded of their rights weekly and patients on Section 3 monthly. Ward managers were sent emails by the Mental Health Act administrators alerting them to when this should be done. We found some isolated incidents at Priority House where adherence to this was not recorded in patient care records.
- Following our comprehensive inspection in March 2015 we told the trust they must ensure that the Mental Health Act is consistently implemented in accordance with the Code of Practice; and that staff working on the acute wards and psychiatric intensive care unit have sufficient understanding of the Mental Health Act and its Code of Practice to ensure patients are given correct information about their rights and to ensure medicine is administered lawfully under the Act. Improvements had been made in the ensuring patients understood their rights and that medicine was administered lawfully. However, we felt that further improvements could be made in staffs' knowledge of the Mental Health Act and its Code of Practice.
- Staff at Littlebrook Hospital told us that there can be delays in approved mental health professionals (AMHP) attending the wards if patients need to be detained. The trust had raised this issue and been informed there were ongoing staffing issues within the AMHP service. Staff at both Priority House and St Martins Hospital felt the AMHP service responded promptly.
- Mental Health Act administrators conducted audits of documents weekly. We spoke to the administrator at Priority House who told us that the weekly audits just monitor dates of expiry and when patients consent is due. They scrutinised paperwork on one ward once a month, therefore, each ward was only checked thoroughly every nine months.
- Patients on all wards had access to independent mental health advocates who were trained to work within the framework of the Mental Health Act and support people to understand their rights under the Act and participate in decisions about their care and treatment. They visited the wards at least once a week and made themselves available to detained patients as well as being available by referral.

Good practice in applying the Mental Capacity Act

- Staff received training in the Mental Capacity Act and its guiding principles and the Deprivation of Liberty Safeguards. All wards had achieved training rates of above 85% apart from Pinewood ward who had achieved 84%. Staff were required to repeat training every three years, however, they told us that the training was not very in depth.
- Staff told us that patients' capacity was discussed and reviewed within their ward reviews but we found a variance in how this was recorded in progress notes and care plans. Staff knowledge on how to assess whether a patient had capacity was generally poor across the service and they told us that the ward consultants took a lead in this area. Staff recorded in patients' care records whether or not they had capacity but we found little detail on how this decision had been reached. Staff had access to the trust's policy on the Mental Capacity Act via the trust's intranet. Following our comprehensive inspection in March 2015 we told the trust that all staff should have an understanding of the Mental Capacity Act and DoLS. This remained a concern.
- Independent mental capacity advocates (IMCA) were available to patients, and how to contact them was clearly displayed on the wards.
- We viewed an example of a best interest meeting having taken place on Willow Suite. A patient, who was deemed as lacking capacity, had an adverse reaction to medicine and may have benefitted from surgery. The patient's family and an independent mental capacity advocate (IMCA) had been invited to a multidisciplinary team meeting to help make a decision in the patient's best interests. We also heard staff on Samphire ward making arrangements for a best interests meeting to discuss a patient's most appropriate housing options.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff were constantly engaging with patients and there was a lot of emphasis on ensuring detained patients were receiving escorted section 17 leave. Ward environments were generally busy, however, we observed staff giving support to unsettled patients.
- We observed many examples of positive interactions between staff and patients. We observed a consultant at Priority House change their approach when a patient expressed they were asking too many questions. Staff and patients had meals together and we observed them engaging in general conversation.
- Patients we spoke with felt that staff treated them with dignity and respect. They told us that staff always knocked before entering their bedrooms. Some patients at Littlebrook Hospital told us that new agency staff did not always introduce themselves and felt this made them unapproachable.
- Following our comprehensive inspection in March 2015 we told the trust they must ensure it had a system to maintain the privacy and dignity of women who were secluded on Willow Suite. Due to the closure of this seclusion room we no longer had concerns around this issue.
- Staff we spoke with on all wards were knowledgeable about individual patient's needs and risks. Patients appreciated staffs' efforts to keep them safe and reassure them at times when other patients were unsettled or there was excessive noise or activity levels. Many patients we spoke with commented that they were comforted by the attention that staff paid to their physical health needs.

The involvement of people in the care that they receive

- All wards had admission checklists which included orientating patients to the ward. All wards employed releasing time to care assistants who were allocated to support patients during the admission process.
- We asked 27 patients specifically whether they had been involved in their care plans. Twenty two agreed that staff had had conversation with them regarding their care plans with 17 saying they had, or were offered, a copy. We checked patients care records and found that staff on all three wards at Priority House and Cherrywood ward were not always recording this information. Patients told us that staff encouraged them to maintain their independence during recovery groups. They also benefitted from speaking to pharmacists about how to manage their medicine independently.
- Patients on all wards had access to external advocacy services. Contact details for these were clearly displayed on all wards. St Martins Hospital only displayed details for an independent mental health advocate (IMHA) who would not generally be available for informal patients. We spoke to the sites acute modern matron about this who confirmed this individual would see informal patients briefly and was able to refer them to general advocates if necessary. This site also had an external patient council who attended patients' community meeting and made themselves available to talk with individual patients. One patient on Willow Suite told us they had an advocacy appointment but was disappointed this was not repeated. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should improve their systems in relation to patients accessing advocacy services. We found this issue had been resolved.
- The trust had included three quality improvements relating to carers' involvement in their current priorities for improvement programme. These were; to increase the number of carers attending patient reviews; learning from the friends and family test feedback; and completion of the triangle of care self-assessment documentation. We found evidence that this service was addressing these areas identified. Priority House had acted on a complaint by a carer and were now giving patients options for when they wanted their reviews. Staff were also allocated to inform carers of when reviews were happening to ensure they had opportunities to attend. The service had audited their compliance to the triangle of care standards. The triangle of care is a therapeutic alliance between patients, staff members and carers that promotes safety, supports recovery and sustains well-being. We spoke with the quality and development lead for St Martins Hospital who told us that some staff were being trained to deliver a family therapy called open dialogue and carers champions on all wards received family inclusive training. All the sites ran carers groups and we heard

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examples how carers, who were initially frustrated, became involved in the running of these. St Martins Hospital were considering moving their carers group to the weekend to encourage more carers to attend. We spoke with five carers who all felt their relatives had benefitted from the service and that they were appropriately involved in their care.

- All wards held regular community meetings where patients could give feedback about their experience on the ward and raise any issues. We saw minutes from the meetings. Some patients on Willow Suite told us they had used the community meeting to inform that their shower was cold but this had not been addressed.
- Priority House and St Martins Hospital displayed feedback from their friends and family questionnaire. Between 1 January 2016 and December 31 2016, Priority House had received 103 responses to the question 'whether you would recommend the service to friends or family', with 62% stating extremely likely, 25% stating likely, and 13% stating other. St Martins Hospital had received 31 responses to the same questions within December 2016 with 61% stating extremely likely, 29% stating likely, and 10% stating other. We received data from the trust to show all wards were receiving responses to this survey with Cherrywood ward receiving the most with 151 and Willow suite the least with seven. We saw 'you say we did' boards displayed in all three sites which explained how the service was responding to patient feedback.
- Patients from Priority House, both current and past, had been consulted about the planned refurbishments for the wards. They had also attended team away days to talk about their experience whilst on the ward.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- All eleven wards had bed occupancy of 100% or over between 1 October 2015 and 30 September 2016. Bed occupancy rates are a measure of available bed capacity. This meant that 100% of available beds were occupied by patients in this time period. During our inspection we saw that when beds were available they were quickly allocated to patients referred from the community crisis teams. All three hospitals had daily bed management meeting to monitor availability and requirement.
- Within this same period, there were 827 patients who were placed in beds outside of the trust due to lack of bed availability. We were told that the trust had worked hard within the last six months to reduce this figure by looking at their discharge planning processes. During our inspection there were six female patients placed out of area in psychiatric intensive care (PICU) beds. This meant that the vast majority of people living in Kent were able to access beds in their catchment area.
- Willow Suite employed two qualified nurses as outreach workers. Their role allowed them to assess patients, who were referred to a PICU, and make recommendations on the level of care they required. They were able to offer support to acute wards, in the form of management plans, if patients had to wait for a PICU bed. They were also able to liaise with settings where PICU patients were placed out of area to ensure they were transferred back to trust beds as soon as appropriate.
- The Willow Suite consultant told us they aimed to respond to urgent referrals within four hours and non-urgent referrals with 24 hours. Ward managers of the acute wards confirmed that access to PICU beds had improved recently, although beds for female patients requiring this level of care, occasionally were not available for 48 hours. This meant they had to remain on acute settings where extra resources were needed to support them. Six female patients were currently in private PICU beds out of area.
- Following our comprehensive inspection in March 2015 we told the trust they must ensure that delays in finding PICU beds for patients are minimised. The service had sufficiently addressed this concern.
- We were told that patients would have access to their bed on return from overnight leave. We attended a weekly planned discharge meeting at St Martins Hospital. We saw that patients were discussed to ensure everything was in place for their discharge. Staff made plans to order medicine in advance so patients experienced minimal delays. This meant they were able to leave the wards at an appropriate time of the day. Staff discussed a patient who was admitted to Priority House purely to initiate them on Clozapine, which is a medicine that requires robust physical monitoring in its early stages. The patient came from a rehabilitation ward and a plan was made to ensure their bed was available when he was ready to return.
- Staff told us that patients were occasionally transferred to different wards if they or other patients were affecting their ability to recovery. We heard an example of this being discussed by staff on Samphire ward who were aware of some historic issues that a referred patient had with another patient currently on the ward. The ward manager shared these concerns during the bed management meeting and alternative plans were made. Staff at Littlebrook Hospital told us that patients are occasionally moved between wards to maintain same-sex guidance. They felt that this had a negative impact on continuity of patients' care. Following our comprehensive inspection in March 2015 we told the trust they should make suitable sleeping arrangements for patients who returned from leave, and reduce the need for patients to change bedrooms for non-clinical reasons. This was no longer an areaof concern.
- We were made aware of some delayed discharges across the service. Patients from Willow Suite would often experience delays in discharge if they required more specialist placements, such as secure rehabilitation settings. We were told this amounted to approximately 10% of patients and we were told that currently a patient had been delayed two months due to unavailability of appropriate setting. Other wards at Littlebrook Hospital currently had five delayed discharges due to accommodation and safeguarding issues. A consultant also felt that one of these delays had been due to poor communication from a patient's

Are services responsive to people's needs?

Good

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care coordinator. Priority House had five delayed discharges due to accommodation issues, waiting for rehabilitation bed and family issues. St Martins Hospital had seven delayed discharges due to accommodation and safeguarding concerns.

The facilities promote recovery, comfort, dignity and confidentiality

- All three sites had therapy and activity rooms provided on the wards or in dedicated areas. For example, Willow Suite had a therapy activities unit with two activity rooms and a large recreation room which contained gym equipment, pool table and table tennis. This was accessible via a swipe card to ensure that patients were appropriately supervised. Patients from the three acute wards at Littlebrook Hospital had access to an on-site therapy activities unit. This consisted of a kitchen, an art therapy room, a recreational room and a resource room. St Martins Hospital were planning to create a therapy unit on the site that would be accessible to patients from all wards.
- All wards had quiet rooms and areas where patients could meet with visitors in private. Patients who did not have access to their own phones could use ward mobile phones to make phone calls in private.
- Patients had access to outside areas on all wards. These areas were only accessible at certain times of the day. We were told this was to encourage patients to engage in ward based therapeutic activities. However, staff told us they used these times for guidance and would let patients use them outside these times if required. At Littlebrook Hospital, the garden areas were quite small. All garden areas had seating apart from Cherrywood ward. Patients on this ward were currently only allowed in the garden supervised due to an identified ligature risk. Garden areas at St Martins Hospital had gym equipment installed in garden areas. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should ensure that outside areas accessible to patients offer comfort and therapeutic benefit. Further improvements in this area were required.
- The trust had introduced a smoke free policy on all their sites in April 2015. We found a variation on how this was being enforced across all three sites. At Priority House and St. Martins Hospital patients were openly smoking inside the hospital grounds. Staff told us there had also been an increase of incidents where patients, who did not have leave from the ward, were found smoking in their bedrooms. Littlebrook Hospital were seen to be more vigilant in ensuring patients left the hospital grounds to smoke and this had led to staff providing regular escorted leave. Staff told us that patients were not supposed to smoke when they were escorted by staff but this was almost impossible to enforce. The trust policy did not allow section 17 leave to be given purely for the purpose of allowing patients to smoke, however, we saw incidences where patients were given more regular leave at shorter intervals to accommodate their smoking needs. Staff felt that the smoking ban did not favour patients who were not able to leave the ward and that often these were the most unwell patients. They also felt the policy put staff at risk of physical aggression from patients. We heard incidents of staff being assaulted and patients being given rapid tranquilisation as a direct result of the smoke free policy implementation. All wards had staff trained in smoking cessation and we saw that options, such as nicotine replacement therapy, were discussed with patients. However, if patients had received this intervention it was rarely included as a care plan.
- Patients across all three sites told us that the quality of food was generally good. Some patients at Priority House told us the variety of food could be improved and had spoken to staff about this. Patients on Bluebell ward and Foxglove ward spoke very highly of the food. These ward had received a patient led assessment of the care environment (PLACE) score of 100% for quality of food. The other wards at St Martins Hospital received a score of 91% with Littlebrook Hospital receiving 72% and Priority House receiving 74%.
- Patients had access to hot drinks and snacks outside of meal times. At Willow Suite these were on request and patients told us that staff were responsive to this. Patients on Samphire ward had to request hot drinks from staff as the hot water machine was broken. Again, they told us staff were responsive to their requests. Staff, across the service, told us that they would monitor requests for drinks after midnight to ensure it was not having an impact on patients' sleep hygiene. Patients and staff at Priority House had access to a patient run canteen that sold sandwiches and drinks during the day.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- We found the temperature on Fern ward to be variable across the environment, with areas of excessive heat and cold. Patients told us that milk provided for hot drinks could go off quickly as they did not have access to a fridge. The ward manager informed us that a new boiler was being fitted and this work would be completed the following week. They also confirmed that patients had requested access to a fridge via their community meeting and this was being looked into. Some patients on Upnor ward said they found their bedrooms cold. We were told that the ward had under floor heating which did not allow staff to adjust the heat. Two patients on Cherrywood ward told us they found their en-suite showers flooded on occasions.
- Patients were able to personalise their bedrooms with items that did not pose risks to people or the environment. Patients were allowed battery operated radios in their bedrooms.
- Patients on most wards had key fobs which allowed them to access their bedrooms at any time. This meant they could close their doors to secure their belongings and not need assistance from staff to re-enter. Fern Ward did not have this technology and patients would often leave their doors open to avoid needing staff to reopen. We heard some concerns from patients that they had items, such as cigarettes and money, stolen from their bedrooms. Following our focussed inspection of Littlebrook Hospital in July 2016 we told the trust they should adopt a system which allows patients to access their bedrooms independently. We found this had been addressed on the majority of wards but remained an issue on Fern ward.
- All wards had a room where patients could securely store their possessions. We saw staff regularly accessing these rooms to respond to patients requests. The lockers on Boughton ward were broken and were not locking. Staff did not record what patients stored in their locker meaning they could be open to accusation if items went missing. All sites had a system whereby patients could keep money securely outside the ward. Patients were encouraged to keep small amounts of money on their person and use this facility to secure larger amounts.
- Patients had access to a wide range of activities seven days a week. These included structured activities as part of the therapeutic day, breakfast clubs, exercise equipment, board games and colouring materials. Priority House and St Martins Hospital offered pet therapy with a weekly pat dog session. Staff used their own skills to provide patients with pampering sessions and musical activities. Patients on Amberwood ward had suggested collecting books for a ward library. We spoke to an occupational therapist at St Martins Hospital who took patients to a local golf driving range at weekends. They used two pool cars and was concerned that there were plans for these to be removed. We spoke to senior management about this who confirmed that, due to excessive maintenance needs, the cars would not be replaced. However, activities like this would still go ahead by using volunteer drivers.

Meeting the needs of all people who use the service

- All wards were on the ground floor and accessible by wheelchair users. Upnor ward had two bedrooms that were adapted to cater for patients with physical high dependency and had hoist facilities.
- Wards only displayed information leaflets in English. However, staff told us that some of the leaflets were accessible in different languages on the trust's intranet and they would print them if required.
- All wards displayed a wide range of information for patients on areas such as, the Mental Health Act, how to complain, physical health and well-being and local services.
- Staff had access to interpreters services and were aware of how to book these. We saw examples of interpreters supporting patients in issues such as safeguarding, best interest meetings and review meetings.
- Patients had access to a choice of food that met all dietary requirements. This included kosher and halal food.
- Patients had access to chaplains who visited the wards regularly. Patients at Littlebrook Hospital told us they were able to attend a pray group and bible class once a week. Priority House held a service for patients fortnightly that was well attended.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- The service received 63 complaints between 1 October 2015 and 30 September 2016. Boughton ward received the most complaints, with 12 (19%). Eleven complaints received related to lack of treatment/care/support (17%). Three of these were from Fern ward and three were from Samphire ward. Eight complaints received related to rudeness of staff (13%). Three of these were from Boughton ward. Seven complaints received related to discharge arrangements (11%). Two of these were from Amberwood ward and two were from Samphire ward. Of total complaints, 15 were fully upheld, 31 were partially upheld, 13 were not upheld and four were still under investigation.
- The service received 71 compliments during the same period. Chartwell ward received the highest number of compliments with 21 and Willow suite received the lowest number with one.
- Patients told us that knew how to complain and would feel confident doing so. We saw examples of patients informing staff of concerns in minutes of community meetings.
- Staff told us they would try to resolve complaints from patients informally. However, if this was not possible they would encourage patients to put their complaints in writing. Staff told us that the trust had a patient experience team, and that one of their roles was to support patients and carers to make complaints.
- Staff told us that complaints were discussed within team meetings and at daily handovers. Staff from Priority House told us they had used feedback from a complaint to help patients and carers feel more involved in their review meetings.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The trust's vision and values were clearly displayed on all wards. Staff agreed with them and told us they were discussed in supervision and team away days. We spoke to staff who had recently attended the trust's induction and they confirmed they were emphasised throughout.
- Ward managers felt their teams consider the trust's values when carrying out their work. They said that exploring these values was an important part of the interviewing process.
- Staff knew who the senior managers in the trust were and were aware of recent changes at board level. Consultants told us they felt more valued as clinical team leaders since changes had been made at board level. Senior managers at St Martins Hospital told us that the chief executive regularly sent them supportive emails in response to incidents. The chief executive had recently done a nursing shift on a ward at Priority House. However, staff at Littlebrook Hospital felt that senior managers only got involved when adverse incidents happened.

Good governance

- All ward managers had access to effective systems that allowed them to monitor staff compliance with mandatory training, supervision and appraisals. There was an effective system that ensured all reported incidents got reviewed and escalated as required. All three sites had daily meetings to ensure that wards were covered with the appropriate amount of staff. This included clear actions plans in how to best share staff resources if wards were short staffed. Medicine management was monitored to a high standard with support from a well-resourced pharmacy team.
- The service had successfully implemented a new staffing model that improved staffs' ability to engage in direct care activities. This model had included the introduction of staff who could focus on clinical audits. Staff had regular opportunities to discuss and learn from incidents and complaints.
- Staff had a good understanding of safeguarding procedures. However, we issues around the Mental Health Act and Mental Capacity Act were generally left to medical staff. Audits around Mental Health Act paperwork were not robust and did not routinely look at quality.
- Following our comprehensive inspection in March 2015 we told the trust they must ensure that its monitoring processes identify gaps and problems in the services, and identify the reasons behind such issues. This was no longer an issue for concern.
- We found some decisions made at governance level had resulted in further issues. These included the salary incentive offered only to nursing staff that had resulted in occupational therapists and psychologists feeling undervalued; and the reversal of the decision to make Cherrywood ward a single-sex environment.
- The ward managers told us they had sufficient authority in their roles and had administrative support. They told us that the introduction of the releasing time to care assistant had further allowed staff to concentrate on direct care activities.
- Staff had the ability to submit items to the trust's risk register, for example, ward managers at Littlebrook Hospital had added the issues around staff recruitment.

Leadership, morale and staff engagement

- Between 1 October 2015 and 30 September 2016 the service had an average sickness rate of 6% across all wards. Willow Suite had the highest rate with 15% whilst Cherrywood ward and Boughton ward had the lowest rate with 1%. The trust told us they had introduced a system that monitored staff sickness and staff who were regularly sick could face disciplinary action. Ward managers told us they ensured this system was used fairly and ensured staff with known health conditions had concessions. Incidences of sickness resulting from physical assaults on the ward were also excluded.
- Staff we spoke with had no current concerns around being bullied or harassed by colleagues. Staff were aware of the whistleblowing policy and their responsibilities to report areas of concern. Some staff were not aware they could raise concerns directly to the Care Quality Commission to help maintain their anonymity.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff told us they generally enjoyed their work and that it gave them satisfaction. Some staff expressed concerns around excessive workloads and felt this was directly related to difficulties in recruiting nursing staff in the trust.
- Staff felt supported by their ward managers. Staff had opportunities for career progression. The clinical modern matron at St Martins Hospital told us that staff were encouraged to discuss their career objectives. This meant the service could plan ahead and already had an idea who future ward managers would be.

Commitment to quality improvement and innovation

- The service had recently introduced a new model of therapeutic staffing. It focussed on providing patients with increased therapeutic activities whilst ensuring that available staff resources were managed more efficient. The service had implemented this new way of working successfully and were planning to research the model.
- The service had worked with an external agency to improve efficiency and clinical outcomes across the service. The service now had a more focussed approach to discharge planning which had resulted in a significant decrease in the use of out of area private beds.
- The service had recently introduced staff recognition incentives where staff could share examples of good practice from their colleagues.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Cherrywood ward was not complying with guidance on same-sex accommodation. This was a breach of regulation 10(1) (2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Patients' risk assessments were not always updated following incidents. • Staff were not always using sufficiently monitoring when patients were using Section 17 leave. These were breaches of regulation 12(1) (2)(a) & 12(1) (2)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staff had not completed appropriate rates of mandatory training in line with trust targets. • Staff had an insufficient understanding of the Mental Capacity Act and its guiding principles. These were both breaches of Regulation 18(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

- Patients on Willow suite did not have direct access to psychological assessment or intervention. Staff had the option of referring patients for psychological assessment but were not doing so. This meant the ward was not offering a comprehensive assessment that met patients' needs and preferences.

This was a breach of regulation 9(1)(a)-(c) (3)(a)-(d)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.