Inadequate

Oxleas NHS Foundation Trust

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

Quality Report

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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)
RPGAD	Green Parks House	Betts Norman Goddington	BR6 8NY
RPGAE	Oxleas House	Tarn Avery Maryon Shrewsbury	SE18 4QH
RGPAH	Woodlands Unit	Millbrook Lesney	DA14 6LT

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Oxleas NHS Foundation 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 Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas NHS Foundation 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	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Inadequate
Are services well-led?	Inadequate

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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Summary of findings

Overall summary

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

- Wards were admitting new patients before being able to discharge existing patients. This meant that patients were frequently moved to make maximum use of beds. However, we heard of three occurrences where patients had to sleep on sofas or mattresses for one night because of the lack of beds.
- Ligature audits concentrated on areas where observations where not taking place and did not include the whole ward, communal areas were left out. There had been five suicides linked to the core service, the latest of which was in May 2016. Staff awareness of environmental risks was not consistent across the core service.
- The trust had mixed gender wards. At times, the same sex accommodation rules were breached by having male patients in female only corridors.
- Medication cards were physically in poor condition and there was inconsistent recording and reviewing of people's medicines. Patient allergies were not documented on the medication cards therefore staff were not aware of any medication that should not be given to patients.
- Not all patients received copies of their care plans.
- The trust did not implement local risk registers that highlighted risks pertinent to individual wards.

However;

- The ward environments were clean, bright and the décor and furniture were well maintained.
- Patients received comprehensive assessments during the admission process and received information on the service.
- Physical health examinations were carried out within a 24-hour period and checks were ongoing during the patient's admission in hospital.
- Psychological interventions were available for patients as part of a group session; one to one sessions were also available.
- Patients were given opportunities to provide feedback on the services they received, such as through tablets and patient experience groups.
- Staff were kind, caring and polite.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as Inadequate for Acute and PICU in patient wards because:

- Ligature audits did not include the whole ward environment and these were confined to unobserved areas.
- In order to ensure patients had access to beds in a hospital close to them the trust regularly failed to meet the Department of Health guidance on eliminating gender segregation breaches . Male patients would be in female only areas and females would be in male only areas.
- Staff awareness of environmental risk to patients was not consistent across the core service.
- There was inconsistent recording and reviewing of medicines on prescription and medicine cards. Medicine administration records were often in poor condition.
- Some allergies were not documented on the medicine cards.
- We found instances of prone restraint being used and some staff were not aware that it should be avoided wherever possible.
- There were inconsistencies in the formal reporting of safe staff numbers from individual wards to trust senior management. This meant that they did not have a clear picture of shifts that were below numbers required.

However:

- Each ward was clean and provided a bright and inviting environment for patients. Wards were decorated to a high standard and patient's artwork and words of encouragement were displayed.

Are services effective?

Good

We rated effective as good for Acute and PICU in patient wards because:

- Patients received a comprehensive assessment on admission.
- There were very good ongoing physical health monitoring and weekly wellbeing clinics taking place.
- Psychological therapies were available to patients, both in groups and in one to one sessions.
- There was good communication between inpatient and community teams concerning bed management, admission and discharge.
- Staff were appropriately qualified and competent to carry out their roles.

Summary of findings

- Staff adhered to the Mental Health Act code of practice and ensured patients' rights were regular read to them.

However;

- Not all patients received copies of their care plans.

Are services caring?

Good

We rated caring as good for Acute and PICU in patient wards because:

- Staff were kind, caring and polite.
- Patients received information on admission about the service.
- Patients had opportunities to give feedback on their care and treatment, staff audited patients' experiences and outcomes. These were displayed so patients could review them.
- Staff involved carers and relatives in patient care.
- Patients had access to independent advocacy.
- Patients who had left the ward had opportunities to share their experiences with others under the 'Lived Experience Practitioners' programme.

Are services responsive to people's needs?

Inadequate

We rated responsive as inadequate for Acute and PICU in patient wards because:

- A number of patients had experienced sleeping on sofas and mattresses on the wards while waiting for a bed to become available.
- Bed occupancy across the core service was above 85%. The demand for beds was above the beds commissioned for the service. This had been highlighted by the trust on their risk register as a major risk. There were also high rates of re-admissions to these wards.
- Patients were informed that beds for patients on leave would be used for new admissions.
- Patients were being moved between wards and locations to accommodate new admissions.
- Patients were anxious about having to sleep on other wards during their admission.

However:

- The trust held daily bed management phone conferences and weekly meetings to try to arrange beds for new admissions. This was to prevent admissions to other NHS trusts.

Summary of findings

Are services well-led?

Inadequate 

We rated well-led as inadequate for Acute and PICU in patient wards because:

- Staff vacancies were the highest across the core services at 16%, the wards relied on bank and agency staff to cover shifts
- Reports of weekly staffing figures were not being completed every week for senior management to determine any issues with staffing levels.
- The trust did not have local risk registers but identified and documented risks by directorates.
- Although risks were identified and the trust were aware of the impact of the risks and likelihood of the risk occurring, no action plans or timescales were documented as having been effectively addressed.
- Whilst staff were aware of the whistle blowing process, not all staff felt able to raise concerns.
- Action plans were put in place following investigations into serious incidents, but risk registers identified that not all lessons learnt were shared with all staff.

However;

- Staff felt supported by their teams and managers, they also felt encouraged to participate in training and development by their managers.

Summary of findings

Information about the service

Green Parks House, Oxleas House and the Woodlands Unit are part of Oxleas NHS Foundation Trust. They provide care and support for people aged 18 and over living with mental illness in the London Boroughs of Bexley, Bromley and Greenwich. Patients were admitted informally or as detained patients under the Mental Health Act 1983.

The regulated activities at Green Parks House, Oxleas House and the Woodlands unit included; assessment or medical treatment for persons detained under the Mental health Act 1983, diagnostic and screening procedures and treatment of disease, disorder or injury.

The wards visited were:

Green Parks House – covering the borough of Bromley:

- Betts ward – a 17 bed mixed gender ward
- Norman ward – a 16 bed mixed gender ward
- Goddington – a 16 bed mixed gender ward

Oxleas House – covering the borough of Greenwich:

- Tarn – a 13 bed male PICU ward
- Avery – a 19 bed mixed gender ward
- Maryon – a 19 bed mixed gender ward
- Shrewsbury – 19 bed mixed gender ward

Woodlands unit - covering the borough of Bexley:

- Millbrook – 20 bed mixed gender ward
- Lesney – 20 bed mixed gender ward

Our inspection team

The comprehensive inspection was led by:

Chair: Joe Rafferty, Chief Executive, Mersey Care NHS Trust

Head of Inspection: Pauline Carpenter, Care Quality Commission

Inspection managers: Peter Johnson and Shaun Marten, Care Quality Commission

The team was comprised of:

- two CQC inspectors
- two specialist advisors (mental health nurses)
- one consultant psychiatrist
- one expert 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.

Summary of findings

During the inspection visit, the inspection team:

- visited nine wards at three hospital sites and looked at the quality of the ward environment
- met with 36 patients who were using the service
- interviewed the managers and modern matrons for each of the wards
- spoke with 29 other staff members; including managers, doctors, nurses and psychologists
- attended and observed three hand-over meetings, three multidisciplinary meetings and a bed management telephone conference
- reviewed in detail 70 care and treatment records
- reviewed 105 prescription and administration cards
- looked at policies, procedures and other documents relating to the running of the service
- observed the staff interactions with and the care provided to patients
- reviewed the "your experience feedback" provided by people on the CQC website

What people who use the provider's services say

We spoke with 36 patients across the core service during our inspection. Patients told us staff were friendly, polite, caring and had their best interests at the core of what they did. They felt safe and comfortable on the wards. They felt they had been treated really well and the service was excellent. One patient told us they had a lot of admiration for staff.

We heard of patients anxieties in the community meeting about having to sleep on other wards due to increased bed pressures. Two patients told us they slept on a sofa while waiting for a bed. One patient said they saw another patient sleeping on a mattress in the activity room.

One patient told us they waited seven hours for a bed after they had come in to hospital in the early hours of the morning.

Good practice

The modern matron told us about the 'Lived Experience Practitioners' (LEP) programme. This was a programme for ex patients who wanted to share their experiences with other patients. On completion of the programme they could apply for posts as health care assistants.

Maryon ward had an employee of the month selected by patients' suggestions and from their feedback. The selected member of staff would have their picture displayed at the entrance to the ward.

Areas for improvement

Action the provider MUST take to improve

- The trust must take action to reduce the number of same sex accommodation breaches.
- The trust must ensure that effective bed management systems are in place to avoid patients having to sleep on sofas and in lounges.
- The trust must ensure that medication cards are accurate and reflect any risks in relation to prescribed medication.
- The trust must ensure that ligature assessments are carried out for all ward areas.
- The trust must ensure that all care plans are person centred and that patients receive a copy of this where applicable.

Summary of findings

- The trust must take action to address and develop local risk registers to include actions and timescales implemented to manage the risks identified.

Action the provider SHOULD take to improve

- The trust should have discussions with commissioners to ensure that the increased demand for beds meets the needs of the population.

Oxleas NHS Foundation 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
Norman, Goddington and Betts	Green Parks House
Tarn, Avery, Maryon, Shrewsbury	Oxleas House
Millbrook and Lesney	Woodlands Unit

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.

Mental Health Act training was not part of the mandatory training for staff.

The trust told us that their expectation of staff who were qualified mental health professionals was that they would have covered the application of the Mental Health Act as part of their training. Specific training was provided for staff such as junior doctors and all nurses during preceptorship.

Additional training took place when identified from incident feedback or specific performance management issues raised in supervision.

Staff we spoke with had a good understanding and knowledge of the Mental Health Act and its application. Support for staff was available from the Mental Health Act office. Audits also took place to ensure compliance with the Mental Health Act and documentation standards.

We reviewed 17 care records of detained patients and found evidence of patient rights being read to them at regular intervals.

Legal detention documentation was completed correctly. These were signed and dated.

Patients had access to the independent mental health advocacy (IMHA) service.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

There was good evidence in the care plans to demonstrate that individual assessments of capacity and consent to treatment were taking place.

Discussions and ongoing assessments took place in relation to capacity. In ward reviews, patient outcomes were documented in progress notes.

Mental Capacity Act training was mandatory and we found that 99% of staff had completed this training.

At the time of our inspection no patients were subject to the deprivation of liberty safeguards (DoLS) safeguards.

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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 each ward meant that corridors were easily visible from the main ward office. Staff were able to observe large parts of the ward from the offices and mirrors were in place to improve all round visibility. The exception to this was at Woodlands Unit where views around the ward were restricted from the staff office and mirrors were not in place to lessen the risk. Staff told us they reduced the risk from blind spots by being vigilant, talking to and engaging with patients, and using the appropriate level of observation.
- Oxleas' ligature policy guided staff to assess ligature risk in areas where a patient 'might' be unobserved. Ligatures are used by patients to cause harm to them. Ligature risks were only assessed for areas such as bedrooms and bathrooms, rather than the whole ward. Staff put in actions to reduce risks in these areas such as ligature proof door handles and collapsible curtains. Staff did not assess communal spaces on the wards for ligature risks. Staff consistently told us that this was because they were observed areas and patients were unlikely to self-harm in these areas. Door shutters, door handles, televisions, smoking areas and taps all posed risks to patients and had not been assessed for their potential ligature risk, nor was any action put in place by the trust to reduce these potential risks.
- We found that while some staff were aware of the risk of the environment to patients it was not consistently understood across all wards. Ligature cutters were available to staff and were in an easily accessible place.
- There was a serious incident involving a patient dying by ligature in their bedroom on Goddington ward within the previous 12 months. An investigation into this took place but this had failed to identify the need for further assessment of the ward for ligature points.
- All wards were mixed gender and had separate male and female corridors with a separate female lounge. Bathrooms were designated male and female and were clearly marked as such. The Mental Health Act Code of Practice states 'all sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms'. We found consistently across the trust that the department of health guidance on the elimination of mixed sex accommodation was breached. Male patients were sleeping in the female areas of the wards due to pressure on beds. We heard from staff that it happened often but that if someone of the opposite sex were sleeping in the wrong area those observations would be increased to mitigate the risk. Staff also tried to find appropriate patients to put in the area who were lower risk to the opposite sex, which therefore meant an unnecessary room move for them with increased observations that were not clinically warranted. Patients stated that moving rooms was commonplace and anxiety provoking for them. When there was a breach of same sex accommodation guidance, we were told that it would then be recorded as an incident in order to flag up the regularity of the occurrence to management. Avery ward at Oxleas House had submitted 75 incidents of same sex accommodation breach over the previous six months. Throughout the core service, there were 117 breaches in the previous six months, further breaches were also recorded but the wards were not identified. Previous Mental Health Act reports undertaken by the Care Quality Commission had identified this as an area of risk that the trust was required to address.
- In April 2016, we had one comment on the CQC website through the 'Share your experience' feedback. A former patient described their fear of being on a mixed ward and said they did not feel safe. They stated that a patient had stolen from their bank account and had stalked them. They did not feel comfortable around members of the opposite sex. They had recovered much quicker on a same sex ward environment.
- Millbrook and Lesney wards had two areas for higher levels of observations. These were close and easily visible from the ward offices so that staff could much more easily observe and respond if needed. Patients

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that were deemed to be of higher risk would be considered for this area. This was also the area where a patient from the child and adolescence mental health service (CAMHS) could be admitted onto Millbrook ward.

- Wards had a fully equipped clinic room to allow staff to dispense medications and offer a place for physical healthcare. Emergency medical supplies such as medicines and resuscitation equipment were in place. These were checked regularly to ensure they were in date and fully functional. Equipment was clean and well maintained and items had been PAT tested February and April 2016. The equipment was next due for testing in 2017. This meant all electrical equipment and appliances were examined to ensure they are safe to use. However, we found on one ward that five millimetre syringes in the clinic room were not in date. We brought this to the attention of the managers at the time and it was promptly resolved.
- Each ward was bright and clean and decorated to a high standard. Furnishings were clean throughout. They were maintained to a high standard throughout and were clutter free. Corridors were clean and clear and communal areas were clean. Cleaning staff were visible on the wards and cleaning records were displayed in ward areas.
- The patient led assessment of care (PLACE) data 2015 for cleanliness at Green Parks House was 98% and 97% at Oxleas House. Overall, the trust scores were good at 97%, the England average score was also 97%. However, Woodlands unit scores were below the national average at 80% for cleanliness.
- The PLACE data score for privacy, dignity and well-being was 92%. This was above the England average.
- Staff conducted weekly environmental risk assessments of wards and clinic rooms to check for issues with the environment that needed to be reported or fixed. This also allowed staff to check for cleanliness.
- Staff understood infection control principles such as maintaining hand hygiene. The inspection team was always reminded to use the alcohol hand gel on entering a ward. There were posters displayed advising staff to wash hands. Staff received mandatory infection control training. Sharps boxes and clinical waste bins were in clinical areas to allow safe disposal of equipment.
- Alarm systems were in place throughout each location. Staff at Green Parks House and Woodlands Unit had personal alarms that staff could use to summon support. However, only Woodlands alarms were connected to a central system. Staff at Oxleas House did not have personal alarms so had to rely on ones placed on the wall around the wards. Inspection staff were concerned that the lack of appropriate staff alarms at Oxleas House reduced staff ability to respond to emergencies.

Safe staffing

- Minimum staffing levels had been set by the trust for each ward. The staffing levels reflected the need of patients and allowed for an increase in observations to be accounted for within the numbers. The staffing levels consisted of a range of nursing bands from support worker to ward manager. The wards worked a system of four staff during the day and three at night. However, the psychiatric intensive care ward (Tarn), operated on five in the day and four at night.
- There was a full time vacancy rate of 21% for the service. The vacancies comprised of health care assistants as well as registered nurses. This meant that bank and agency staff were relied on by each ward. From October to December 2015, the Tarn had the highest amount of shifts filled by bank and agency staff at 438. The lowest was Goddington ward at 243 shifts. We heard that where possible senior managers would try to get their regular staff to cover extra shifts before resorting to bank and agency workers. Staff told us that they used these temporary staff as a last resort and would always endeavour to book staff that knew the wards well.
- The staffing levels for each ward were reported back weekly to the service management so that immediate staffing issues could be rectified. Issues with an increase in observations, groups or outings could be addressed with extra staff booked.
- Data requested from the trust showed that there were shifts in the previous three months to the inspection below the numbers clinically required. This means that staff were working below the safe staffing levels set by the trust. Due to the data being incomplete with

numbers not submitted by every ward each week, senior management did not have the exact numbers of shifts that were below. We were unable to report on the exact numbers of shifts that were below numbers.

- Bank and agency staff were inducted to the ward using a formal temporary worker induction checklist. This ensured that they were aware of ward procedures and policies.
- The ward managers told us the trust had held recruitment roadshows at various locations. Advertisements were also placed on buses. Some applicants were being recruited following this process. The ward manager on Shrewsbury ward said interviews for a health care assistant had taken place to fill the two vacant posts on the ward.
- Staff were visible on the ward to observe and interact with patients. The trust had implemented Patient Engaged Time (PET), which was an hour each day of protected time where staff would not be in the ward office and would be out providing 1:1s and interacting with patients. Staff were allocated patients each shift so that staff knew who they were to support and patients had a named person. We found that staff were able to give as a minimum 15 minutes of 1:1 time twice daily if patients wanted it.
- Staff planned section 17 leave provision throughout the week so that staff could be allocated to support this. Staff told us that patients detained under the mental health act were limited to 30 minutes leave twice per day due to staffing levels. We found that therapeutic groups were rarely cancelled and tended to be a priority, but occasionally there were times when leave had to be cancelled due to staffing levels to ensure that the ward was kept safe. Ward managers were supernumerary and confirmed that they would try to facilitate leave if possible.
- Shifts were planned so that there were responders to emergency situations. This meant that an emergency or incident on one ward could be addressed with the support of staff from other wards. Due to the wards working together in this way they were able to support each other to ensure that there were adequate numbers of staff to carry out physical interventions. Staff were trained in Prevention and Management of Violence and Aggression (PMVA) so that they were able to respond to incidents of aggression confidently. Staff were confident in dealing with aggression and reported that the use of restraint was always a last resort. The completion rate of PMVA training for the service was 92%.
- Medical staff told us that there was adequate medical cover throughout the day and night. Doctors provided cover out of hours through both the consultant and junior doctor rota. This meant that ward staff were easily able to access medical support for patients.
- Staff received mandatory training from the trust with a completion rate of 96% for the service. Mandatory training covered essential areas of knowledge such as Safeguarding, Fire Safety, Infection Control and Health & Safety.

Assessing and managing risk to patients and staff

- Each ward had incidents of restraint in the six months prior to the inspection, totalling 230 incidents altogether. There was a high incidence of prone restraints making up 73 of the 230 incidents. The highest number of prone restraints was on The Tarn with 41 occurrences. The Mental Health Act Code of Practice advises against the intentional use of prone restraint and NICE guidance advises that it should be avoided. Staff were confident in dealing with violence and aggression and told us that they would always seek to de-escalate a situation first. Staff at The Tarn did not have use of a seclusion room so talked about dealing with aggression in patients bedrooms where possible in order to avoid ward disruption, planned restraints would also take place in bedrooms. However, not all staff we spoke with in the trust were aware that prone restraint should not be used.
- Across the service there were 16 prone restraints resulting in rapid tranquilisation with ten of these happening on The Tarn. Staff were aware of procedures for rapid tranquilisation but we were not always able to find the rapid tranquilisation policy on the ward. We were concerned that this meant agency or bank nurses who were not able to access the trust intranet would not be able to follow the policy when needed. We found that rapid tranquilisation was not always being prescribed for specific incidents and there were incidences where rapid tranquilisation medication was being given regularly once prescribed.

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Are services safe?

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- Staff conducted risk assessments for patients on admission and there was a 72-hour period where staff continued to assess patients' needs. We found comprehensive admission assessments by doctors recorded in the notes. Admission assessments helped shape the care for the individual patient. Risks were identified and addressed in care plans in order to mitigate risks. Risk assessments were present, up to date and completed to a good standard. We found that the formal risk assessment tool in the trust's electronic care records was not always being used, however, staff were able to identify where the up to date risk assessment information was kept.
- Staff were aware of individual patient risk and how observations and engagement were used to mitigate this. Staff used varying levels of observations from intermittent to constant observation and this was guided by the risk assessment as well as continued assessment of patient risk.
- There was a blanket restriction with the activity room on Goddington Ward being locked without it being individually assessed for each patient.
- All wards were locked. There were notices on the doors at each site informing patients of their rights and, if they wanted to leave, it advised them who to approach. Staff assessed capacity for informal patients to stay on the ward for the initial 72-hour assessment period and sought their consent for this.
- Wards had a list of banned items, which meant that patients' belongings needed to be searched on admission and after leaving the unit. Staff were sensitive with their handling of patient searches and always sought to gain consent from the patient first. Staff did it as a collaborative effort and spoke of the procedure with good understanding. Sniffer dogs were used to check the ward for illegal substances. There had been previous incidents where illicit substances had been found on the wards.
- Staff received safeguarding of vulnerable adults and safeguarding children training as part of their mandatory training. Staff followed safeguarding procedures and were aware of how to make a safeguarding alert. We found that incidents on the ward were considered for safeguarding alerts where necessary and these were sent through the trust's electronic incident recording system.
- We reviewed medicine cards in detail on all wards we visited. We found that across the service, with the exception of The Tarn, that the medicine administration record charts were of a poor quality and in poor condition. There was often unclear dose information and it was unclear who had made changes to the prescriptions. There was not always an admission date, status, the name of the consultant was sometimes missing, there was no separate slot for injectable medicines and there was not always evidence that medicines reconciliation had taken place. We reviewed 105 medicine cards across the service. Of these; 27 had not had PRN medicines reviewed for more than 14 days, eight had more than one antipsychotic prescribed, three had antipsychotic medicines prescribed above BNF limits and eight had PRN hypnotics given for more than seven nights.
- Medicines were stored appropriately in the clinic rooms. Controlled drugs cupboards were in place and staff checked the contents periodically. There were very large amounts of medicines in clinic room cupboards. This was in spite of the pharmacist weekly visit to undertake specific checks of the medicine cards and storage. Feedback from pharmacy visits was left with the nurse in charge in order for them to address any issues.
- Children were not allowed onto the acute wards. There were external visitors' rooms available subject to individualised risk assessments.

Track record on safety

- Data received prior to inspection showed that there were eight serious incidents requiring investigation in the service in the period 03/12/14 to 01/12/15. Five of these serious incidents were connected with Goddington ward and four of these were suicides. One of the suicides was committed on the ward. Recently in May 2016, the trust reported the suicide of a patient on leave from Betts ward. An enquiry was being held regarding the serious incident.

Reporting incidents and learning from when things go wrong

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- Staff were aware of what to report as an incident. They used the electronic record system to report incidents in order for the trust to have oversight of issues on the wards. We found that incidents of aggression, restraint, and gender separation issues were all reported. Learning from incidents was fed back to ward staff in their weekly business meetings by managers who had an overview of incidents on their wards.
- Staff confirmed that following incidents on the ward there were debrief sessions for staff and patients. There were weekly meetings to discuss specific incidents amongst the staff in reflective practice.
- The trust had introduced new leave assessments following serious incidents. These meant that patients leaving the ward were assessed specifically for that leave, their risk assessment was checked and the description of their clothing was taken. This new approach to the granting of leave was implemented throughout the trust.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Across the core service we reviewed 70 care and treatment records, 17 of which were of detained patients. On admission, patients received a comprehensive assessment within 24 hours. Patients were risk assessed over a three-day period and then continuously following the initial assessment. We saw evidence of ongoing physical healthcare monitoring in the care plans and staff gave patients physical health questionnaires to complete.
- Care plans were up to date and comprehensive, risk assessments were good and in line with the care plans. There was evidence of patient involvement in care planning. Staff recorded when patients declined to participate in completing their care plan. However, they did not always document if the patient had received a copy of their care plan. We found out of the 70 care records reviewed; 20 patients had not received a copy of their care plan.
- Maryon ward displayed monthly audits on their 'Productive Ward Board'; the initiative began in March 2016. The information we saw dated from March to April 2016. The audits of care plans included the following information; the percentage of completed care plans (85%), care plans discussed with patients (95%). It recorded the percentage of patients views reflected within the plans (85%), and the patients given a copy of their care plan (80%). This showed transparency and a willingness to make improvements for everyone involved.
- Information was stored correctly. Care and treatment notes were held electronically and staff had access to patient centred information at all times. Paper records were secured in locked filing cabinets.

Best practice in treatment and care

- The safer wards initiative was used; it had different modules to promote de-escalation. The 'knowing each other' board was one of the modules, where pictures of staff, their names and hobbies were displayed. There was the comfort box, which had items such as soft balls that patients could use. Staff said if things got bad, they would support and escort the patients to their room to de-escalate. We observed staff de-escalating a situation on Norman ward by escorting the patient to their room. This reduced the anxieties of all patients.
- Staff used information form the National Institute for Clinical Excellence (NICE) guidance available on the trust's intranet. It provided positive practice prompts for certain diagnosis'. An example would be being prompted to ask whether physical assessments had been carried out. Staff reported it was helpful and reduced the amount of time spent looking through the whole document. This was also very useful to prompt staff in best practice and to consider evidence-based psychological interventions.
- We found that NICE and Maudsley guidelines were being followed in prescribing. The emergency medicines across the trust met both the NICE and Resuscitation Council's guidelines. This meant that medicines for resuscitation were available according to local policy.
- Staff used the modified early warning score (MEWS) to monitor patients' health. Across the core service, wellbeing clinics were held once a week to carry out physical health checks. There were MEWS champions and leads for physical health monitoring.
- Patients had access to psychology sessions. One to one sessions were offered as well as group work. We attended two psychology group sessions, one of which was held during a community meeting. We saw that outcomes of group sessions such as discussions about stress triggers and coping mechanisms were displayed on the information board. Patients told us they attended group sessions once a week and had one to one sessions with the psychologist.

Skilled staff to deliver care

- There was a range of skilled staff delivering care to patients on the wards. Social workers and approved mental health professionals were available to support both staff and patients with social and mental health matters. Staff morale appeared good and staff were motivated and committed to deliver good quality care to patients.
- Staff told us secondment opportunities were available for staff such as nurse training. We spoke with a former health care assistant whom the trust had funded to complete their nurse training.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Another staff member said opportunities were presented to complete a foundation degree course in health and social care. This was also funded by the trust. Staff said the trust had a good training budget and were good at motivating staff to develop.
- The percentage of non-medical staff appraised in the last 12 months was above 85% for the core service. On the Tarn ward, it was 74%. Supervision records showed the core service were above 85%; however, Shrewsbury ward had 79% completion rate and Goddington ward 82%. Ward managers told us the trust expectation for supervision was every six weeks. Supervision was shared across the team so managers supervised senior staff and junior staff received supervision from senior staff.
- The ward manager on Shrewsbury ward told us staff also arranged clinical supervision. The manager was aware of who the supervisors were and the dates were put in the ward diary and reflected in the staff rota.
- Reflective practice sessions happened across the core service on a weekly basis. Staff said it helped to work out better strategies of managing situations as a team.

Multi-disciplinary and inter-agency team work

- The multi-disciplinary team included nurses, health care assistants, doctors, occupational therapists and psychologists.
- Handover meetings took place across the core service three times a day. Qualified and unqualified staff and the ward manager attended these. Handover sheets were available as an online tool on the trust intranet. It was prepared and updated prior to each handover by the shift co-ordinator. It included information such as patient's name, allocation of responsibilities for staff, observations and nurses on duty.
- We observed the handover meetings on four of the wards. Staff discussed patients individual risks, physical health information and diet. One patient had required assistance to attend a general hospital for treatment. They needed encouragement to attend to their physical health. Staff discussed a plan agreed by the team on the approach required to ensure the patient received follow up of medical treatment.
- Bed managers meetings were held weekly with daily telephone conferences also taking place. There was evidence of effective communication between the inpatient, community and crisis teams. This involved discussions about patient admissions, available beds and discharge planning.
- Staff showed us evidence of how they worked with social services in order to achieve positive outcomes for example at discharge. Wards had a safeguarding lead as well as a social worker.
- Ward managers told us that social workers attended multidisciplinary team meetings if they were involved with the patient. Care co-ordinators were invited but if they were unable to attend they could be use a video link.

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

- The trust had not submitted figures for completed training concerning the Mental Health Act as the training was not mandatory. On Shrewsbury ward, the manager explained learning was available on the intranet and learning outcomes tested within team meetings. Medical staff were required to complete mandatory Mental Health Act training.
- The trust had a central Mental Health Act administration office available to support staff. They had provided a presentation for staff on the new Mental Health Act code of practice. Ward managers told us copies of the new Mental Health Act code of practice were available to staff in the ward offices. These were seen on all wards. Approved Mental Health Practitioners (AMHPs) were available for advice and support. Most trust staff demonstrated a good understanding of the Act.
- Regular audits were completed to ensure the Act was being applied correctly.
- We reviewed 16 records of detained patients during our visit. We found detention paperwork correctly completed and accessible within the care records. Dates of when sections had commenced were clearly documented.
- Patient's rights under section 132 of the Mental Health Act were explained to patients on admission to the wards. We saw evidence within the care records of staff periodically reading rights to patients. Staff also completed an admission checklist, which included reading the rights to the patient and recorded this appropriately.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Advocacy for the Woodlands unit was provided by 'MIND' in Bexley. We also saw information for Rethink advocacy services. We spoke with one of the advocates who said there were four people on the team covering different areas.
- Detained patients were offered support from the advocate. They attended ward reviews and community meetings if requested to do so. Advocacy information was also given to informal patients. An example was given where because of the advocate's intervention the patient asked them to attend a Mental Health Act assessment. They also attended tribunals.
- Advocates had good referral rates from ward staff including psychologists and occupational therapists.
- Across each ward there was information about advocates, patient rights and tribunals was clearly displayed. Information was displayed on the locked ward doors for informal/voluntary patients. Information leaflets also explained the term 'voluntary/informal patient. It explained what to expect as a patient on the ward and what to do if they wanted to leave the ward.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act training was mandatory across the core service. 99% of the staff had completed the training and were up to date. Ward managers told us that recently staff had just completed training. There had been an increased focus on the Mental Capacity Act since October 2015.
- Staff told us the doctors carried out capacity assessments. However, the ward manager on Norman ward explained that staff were supported to carry out capacity assessments. The assessments included consent to treatment, unaccompanied leave and accompanied leave.
- On Lesney ward, we viewed 17 medical cards. There were twelve detained patients; however, consent to treatment and capacity forms were attached to only five medication cards.

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

- We observed good engagement by staff with patients and a genuine effort to meet with patients to plan their day. Staff interacted with patients in the communal areas, taking part in word play and newspaper headline discussions. On Betts ward from 10:30 to 11:30, each morning was protected one to one sessions for patients with their named nurse.
- On Norman ward, we observed staff interactions with a patient who was distressed and quite vocal in relation to this. Staff's management of the situation was respectful of the patient's privacy, and considered the effect that this may have had on others. Staff delivered practical and emotional support in a timely manner throughout the day to patients. This helped restore the settled environment and assisted the patient to achieve their intended goal with minimal distress.
- We spoke with 36 patients across the core service and attended four community meetings. Patients we spoke to were complimentary about the staff, 28 of the 36 patients felt staff were kind, caring and polite. We had a report from an ex patient who said staff had supported them in their recovery.
- The modern matron told us about the 'Lived Experience Practitioners' (LEP) programme. This was a programme for ex patients wanting to share their experience with other patients. On completion of the programme they could apply for posts as health care assistants.

The involvement of people in the care they receive

- On admission, staff provided welcome booklets that had information for both patients and carers on the service. Staff orientated patients to the ward, carried out property checks and offered drinks. This helped to ensure that patients felt welcomed to the ward.
- We observed ward reviews where patients discussed their care plans with staff. Staff said interpreters were provided for all ward reviews. This supported the patients to have maximum participation and understanding of their care plan. We spoke with patients who were able to tell us that they had an interpreter.
- Patients told us they were involved in their care plan and had received a copy. One patient said they recently changed their care plan and another said they were in the process of completing theirs. We found care plans were recovery orientated and holistic taking in to consideration patients' strengths and goals.
- Patients had access to independent advocacy. Patients said that staff had informed them about advocacy and how they could be contacted. One of the advocates told us they attended the wards twice a week.
- Staff engaged with carers and families to obtain their views to help get the correct treatment for the patient. On Millbrook ward, staff checked with patients, family members and carers if they had a copy of the care plan.
- Carers' meetings and groups took place in the evenings. Some staff would also attend. The modern matron for both Lesney and Millbrook wards told us they were actively involved in the meetings.
- Daily community meetings took place across the core service. We attended four of them on Millbrook, Avery, Lesney and Shrewsbury wards. These were well attended by staff and patients. The level of engagement by patients and encouragement to participate varied from ward to ward. On Avery ward, patients chaired the meetings and took the minutes as well as going through the minutes of the previous meeting. On Shrewsbury ward, patients discussed ward issues such as patients cleaning up after making drinks.
- Staff wanted patients to have their say on what mattered to them therefore they encouraged them to participate individually. Those who did not answer or did not wish to take part were not pressured into doing so.
- Patient experience meetings were held across the core service to obtain feedback. Betts ward held them twice weekly. The minutes of the meetings were displayed on the information boards. On Maryon and Lesney wards ward we saw audits of the patient experience including admission process and collaborative discharge planning.

Are services responsive to people's needs?

Inadequate

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

Our findings

Access and discharge

- The trust data recorded bed occupancies from October 2015 to March 2016. The occupancy figures differed on each ward.
- Lesney ward had occupancy rates of 102% in October 2015 which reduced to 97% in March 2016.
- Millbrook ward had 98% bed occupancy rates which reduced to 96% in March 2016.
- Betts ward had 99% bed occupancy in October 2015 which increased to 100% in March 2016.
- Goddington had 99% occupancy rates from October 2015 to March 2016.
- Norman ward reduced their bed occupancy rates from 116% in October 2015 to 104% in March 2016.
- Avery ward had 113% bed occupancy which reduced to 108% in March 2016
- Maryon ward had 115% which reduced to 110% in March 2016.
- Shrewsbury ward had bed occupancy of 126% which reduced to 109% in March 2016.
- The Tarn reduced the bed occupancy from 91% to 77% in March 2016.
- At Green Parks and Oxleas House each ward had between 16 and 19 beds. In addition to this, they each had one surge bed. These beds were used when there was a sudden increased demand for beds. Staff said the surge beds were used daily. This meant that the surge beds had become part of the normal bed status. Patients we spoke to in those rooms had a length of stay ranging from two days to a week.
- The Tarn (PICU) had 13 beds and no surge beds, however two sleepover beds were located at the end of the ward separated by locked doors and managed by extra staff. The sleepover beds were used for existing patients from other wards to sleep in to accommodate new admissions. The patient would sleep there for as long as necessary, returning to their ward during the day.
- At the Woodlands unit there were no surge beds. When wards were full and beds were required for new admissions staff arranged for patients to use the sleepover beds at the Tarn. Lesney and Millbrook ward at the Woodlands unit had high dependency beds used for either male or female patients.
- Staff made patients aware on admission of the possibility of them 'sleeping out', this meant patients could be asked to spend the night in the 'sleep over beds' at The Tarn. They could be assessed for home access or section 17 leave.
- All staff told us bed pressures were the biggest issue and that the situation had been intense during the previous 12 months. When the demand for beds was high patients were moved between areas. A male patient in a female corridor would go on one-to-one observations. Staff said they sometimes had to "make people comfortable on the ward" when no beds were available. Any patients moved between wards were recorded on the trust electronic system as an incident.
- Three patients told us of their experience of admission to the hospital. There were no beds available at the time so two of them slept on a sofa for the first night and reported that another patient slept on a mattress in the activity room. One of the patients waited 12 hours for a bed to become available.
- The beds of patients who were on leave were used for new admissions. On returning to the ward if it was assessed that the patient required admission a bed would be found for them using the same process for a new admission. Staff told us a red, amber, green (RAG) rating system was used to determine risks for patients who could be sent on home access or section 17 leave. The MDT signed off the risk assessments before any patients could leave the ward. This action came because of recent serious incidents.
- Data from the trust highlighted three wards with the highest number of readmissions within 90 days. Millbrook had 32 readmissions, Maryon 26 and Shrewsbury 23. Adult mental health wards overall were amongst the highest in both delayed discharges and readmissions within 90 days.
- Across the wards from 1 April 2015 to 31 March 2016, there were 45 patients experiencing delayed discharges. There were a total of 2738 delayed discharge days

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across the core service. The highest number of days was on Lesney ward where six patients had delayed discharges of 635 days between them. The lowest was on Millbrook ward at 132 days for two patients experiencing delayed discharges. The Tarn reported no delayed discharges during this time.

- The ward manager on Shrewsbury ward told us as part of the assessment staff asked patients about their housing. A staff member was the lead for housing and supported patients in completing housing application forms. During the bed management meetings the multidisciplinary team also supported applications for housing and temporary housing need.
- The trust was working towards aligning their reporting with other London NHS trusts and also with the benchmarking programme. Once fully implemented this would enable the trust to measure their performance against other NHS Trusts. They presented further figures for bed occupancy from October 2015 to March 2016 to include the sleepover capacity. Five of the nine wards visited recorded figures below 100% bed occupancy.
- Multidisciplinary team meetings took place daily. Bed managers were informed of patients discharged by the consultant or assessed as being able to have home access or section17 leave. During the inspection, there was an admission to Lesney ward and there was no bed available. We observed conversations between staff about ensuring that a bed was provided and that potential discharges would be discussed in a multidisciplinary team meeting.
- The trust held bed management meetings once a week and two daily telephone conferences. These focused on moving patients around to facilitate bed space. We took part in one of the telephone conferences which included managers from the inpatient and crisis teams. Representatives from the Woodlands unit, Oxleas House and Green Parks House were also present. The attendees provided up-to-date information on bed status, a review of admissions waiting for beds, accelerated discharges to accommodate new admissions and patients that were in beds outside of the trust area and possible return dates.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards provided a range of rooms to support patient treatment and care. These included clinic rooms, female only lounges, communal lounges, consulting and activity rooms. Some of the male patients we spoke with felt there should also be a male only lounge. On Lesney ward, they had a gym that patients could use following a physical examination by the doctor. Ward facilities included computers, snooker tables, darts, books, and arts and crafts materials.
- Outside space for access to fresh air was also available, on Betts ward patients accessed the courtyard supervised by staff.
- While quiet areas were available on the wards, there were no dedicated areas for patients to meet visitors. Patients felt there was no privacy and felt it would be better if they could meet visitors in a quiet area.
- At the community meeting on Lesney ward, some patients spoke about how they felt intimidated by visitors. They suggested that staff should be present during this time to provide support. Staff acknowledged this but also felt that it would be intrusive to patients with visitors.
- Patients had access to mobile phones and could make private calls in their rooms. On Shrewsbury ward staff told us relatives called patients on the ward phone. Staff would ask them to call the patient on their mobile phone or the pay phone for privacy.
- The menu rotated every four weeks. The wards at Green Parks House enjoyed cooked breakfasts twice a week. However, this was not consistent across the trust. Oxleas House served cereals for breakfast however, no cooked breakfast was available.
- We found most patients were complimentary about the food. However, three patients felt the food was bland, with no fresh vegetables or low fat options available. Patients who had Halal meals had the same food every day and Afro Caribbean patients were not catered for at all. One member of staff on Shrewsbury ward told us the trust had recently started to provide choices for black and ethnic minority patients. There was no information presented on the PLACE survey score for ward food from the trust.
- On all of the wards visited there were designated areas with facilities available for patients to make hot or cold

Are services responsive to people's needs?

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drinks throughout the day and night. At the Woodlands unit the designated area was open from 7am to midnight; however staff would provide drinks to patients on request.

- Patients were able to personalise their rooms to an extent. This was not always encouraged due to the nature of the wards with patients being moved. On Norman ward the ward manager told us due to infection control some items were not seen as appropriate to bring on to the ward. An example of this was a quilt that a patient had brought on to the ward.
- Patients could store valuables in secure lockers on the wards. Staff would supervise access to the lockers and items obtained. This meant that banned items such as mobile phone chargers were not used unsupervised in the main ward environment.
- There were planned activities available during the week. On Maryon ward, the health care assistants facilitated the activities such as soup and smoothie making and arts and crafts.
- The occupational therapists team ran tools for life programmes, exploring different subjects each week like stress and social inclusion. Other wards did similar programmes through the community meetings as observed on Shrewsbury ward. This enabled patients to explore emotions and develop skills around coping mechanisms.
- Some patients felt that there could be more activities and said activities were only available five days a week. During the community meeting on Millbrook ward patients reported they were bored. The feedback from staff varied across the core service. On some wards there were activity coordinators that worked with the occupational therapist to create activity plans over seven days. Other wards had health care assistants that planned activities according to their own hobbies, interests and expertise.

Meeting the needs of all people who use the service

- All wards were wheelchair accessible. Occupational therapy assessments were carried out for those requiring adaptations during their admission. However, bathroom and toilets did not have fixed adaptations to support disabled access. Therefore, as the equipment was not readily available patients had to wait for support prior to using the facilities.
- Signs on bedroom doors indicated whether patients needed support in the event of fire or evacuation procedures. The mobility of individual patients was checked on admission in order to determine the level of support required.
- On each ward there were 'You said, We did' and 'your views matter' posters, with examples of changes made because of patient experience feedback. Examples of this were patients being more involved in discharge planning.
- Information leaflets were available on the intranet for patients who spoke different languages, which staff printed when required.

Listening to and learning from concerns and complaints

- Information received from the trust about complaints received were as follows:
- Millbrook ward – nine complaints received, none fully upheld and four partially upheld.
- Goddington ward – six complaints, one fully upheld and two partially upheld.
- Avery ward - five complaints, none fully upheld and five partially upheld.
- Shrewsbury ward – five complaints, one fully upheld and one partially upheld.
- Lesney ward – four complaints, none fully upheld and one partially upheld.
- Maryon ward – four complaints, none fully upheld and three partially upheld.
- Betts ward – two complaints received, none fully upheld and none partially upheld.
- Responses to written complaints showed the fulfilment of the trust's responsibility of duty of candour. On Shrewsbury ward, the ward manager told us about a complaint from a visitor concerning confidentiality. The visitor had expressed concerns they were able to see the patient board in the nurses' office. This contained the

Are services responsive to people's needs?

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patient's name, date of birth and other confidential information they felt should not be visible. A formal complaint was made and the result was wards were given new boards with shutters to protect patient confidentiality

- During the four community meetings attended, staff addressed issues and concerns raised by patients. On Lesney ward, staff read out the minutes of the previous meeting. Patients had been concerned about sleeping over on other wards away from their allocated ward. Staff addressed this matter by explaining the decision to move patients was carefully considered. They would only ask patients who were assessed as appropriate to move. The feedback provided by staff was in line with the information provided in the patients welcome pack.
- During the community meeting on Millbrook ward at least four patients complained about being ignored by staff and some staff having bad attitudes towards them. Staff asked them to speak to their allocated nurse if they wanted to talk about it. However, some of the complaints were about patients not knowing which staff to approach. Patients also had complaints about a Child and Adolescence Mental Health (CAMHs) patient admitted to the ward. They said it was very sad and distressing for them. Following the meeting, staff shared significant information with all staff on the ward. On Maryon ward comments received through the community meeting were followed up by staff and outcomes discussed at the next meeting.
- Feedback from the 'Share your experience' survey on the CQC website shared a complaint made to the trust by a carer. The complaint was made in July 2015 and was about poor communication between the carer and the Oxleas unit and poor support. The ward was not identified; the carer received a letter from the trust in October 2015, but stated the issues continued until January 2016.

Are services well-led?

Inadequate

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

- Ward managers told us the vision and values of the trust were included in the team and individual objectives. They were also discussed at team meetings and staff were in agreement with them. The trust values were; user focus, excellence, learning, responsive, partnership and safety. We found posters on the walls displaying the trust values.
- Staff incorporated their own ward's visions and values with the trust. On Shrewsbury ward they included improving lives, respect and dignity. Staff said they were aware of the trust board and that senior staff had previously visited the wards.

Good governance

- The risk register identified risks for directorates. The risk register presented to us was for both adult mental health and adult learning disabilities. The level of risks were rated using the red, amber green (RAG) rating system the trust also added yellow to their system. Red was identified as a significant risk, amber high risk and yellow moderate risk. Consequence and likelihood of the risk happening were also determined using the same system. The risk register helped the trust to monitor risks and the associated impact and consequence. However although the responsible group to manage the risk was identified there were no actions or timescales documented. As of 6 May 2016, the risks identified for adult mental health concerned the increased demand for beds. The risk was identified as major as the demand for beds would continue to be above beds commissioned for the service. Another of the risks highlighted, concerned the trust not embedding and sustaining lessons learnt from serious incidents. The trust stated recommendations and actions might not be implemented and reviewed after the action plan had been signed off. This was particularly concerning as following the four suicides on Goddington ward a recent suicide took place May 2016 with a patient on leave from Betts ward. One suicide happened on the ward and others following leave or discharge form the wards.
- Whilst risks were registered by directorates there was a lack of registering of risks at a local level. Risks pertinent to individual wards, staff issues or elements of omissions that may have meant staff training was in order were therefore not registered in a way that escalated the concerns of the particular ward. We were concerned that this lack of governance meant that site-specific risks were not addressed effectively.
- The adult and PICU services had the highest vacancy rate at 16%. Wards relied on agency and bank staff to cover vacancies of health care assistants and nurses. Ward managers and staff told us they tried to get regular staff members to cover extra shifts. This was the first option before resorting to using bank or agency staff; they tried to use staff they were familiar with. Weekly staffing figures were reported to the service managers. However, we were unable to clarify actual weekly staffing levels for every ward as the information received had missing weeks. However, the trust had responded positively to the issue with a recruitment drive that had been successful in providing offers for a large portion of the vacancies.
- Action plans were developed from serious incidents to share lessons learnt and change practices. We saw that ward managers were aware of the change in practice for patients that were re-admitted. Staff were required to have discussions about the patient and share information between the discharging and admitting wards. We saw that physical health monitoring was part of the ward hand over meetings and was on the templates for discussion. This was part of the action plan developed following a death of a patient. There were concerns raised through the risk register that not all lessons learnt were being shared with staff.
- Staff completed mandatory training. E- Learning was available on the trust intranet. Human resources had a learning zone that staff used to update their learning and development. There were systems in place to monitor completion of mandatory training and appraisals.
- There were trust wide clinical effectiveness groups that also took place at a local level. National treatment guidance was reviewed and audited and measured against. Audits of medicine administration records (MAR) took place to check for compliance with prescribing guidelines.

Are services well-led?

Inadequate

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.

- NICE guidelines were reviewed in the clinical effectiveness group and the outcomes disseminated to the wards. An audit newsletter was produced and sent to staff to inform them of audits carried out and guidance.
- Staff received monthly supervision and yearly appraisals which were all up to date. Staff also arranged clinical supervision of their colleagues, managers were aware of the dates of times of meetings. The trust offered online training to assist with nurse revalidation.

Leadership, morale and staff engagement

- There was a staff sickness rate of 4% over a 12-month period across this service.
- Staff told us they were aware of the whistle blowing policy and knew how to use raise concerns. At the time, it was felt that they would not be listened to due to the seniority of the person they would be reporting. Therefore, they did not feel able to raise concerns without fear of victimisation. The trust reported that they had 24 bullying and harassment advisors from the BME, LGBT, LEN, and DAG networks. Staff received support from human resources, staff counselling was offered and one to one discussions with the modern matron were available. A staff away day was arranged to support staff and provide reassurance.
- Staff reported feeling happy in their roles and felt supported by their teams and management. There was consistent positive feedback from staff about their immediate managers stating they were very approachable and supportive.
- Staff told us they were aware of the duty of candour requirements and gave examples of when they have apologised to patients or relatives when things have gone wrong.
- Ward managers were encouraged to develop their leadership skills. The ward manager on Norman ward encouraged one of the charge nurses to complete their leadership course. Motivational interviewing, phlebotomy training, secondments for nursing and university courses were available to all staff. The ward manager was encouraged to complete their Masters' course in nursing to add to their degree.

Commitment to quality improvement and innovation

- The patient experience group had been established to provide assurance and improve patient experience across services. Comprehensive feedback received form the group was used to assist to enhance the quality of care.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. This was because: The ward had high bed occupancy levels and patients were nursed on sofas and in lounges. The trust did not have local risk registers to record the actions and timescales implemented to manage the risks identified. The trust did not ensure that ligature assessments were carried out for all ward areas. The trust did not ensure that medication cards were accurate and reflected any risks in relation to prescribed medication. This was a breach of regulation 12 (1) (2) (a)(b)(d)(e)(h)

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 Patients were not fully protected against the risks posed to their privacy, dignity and respect. The trust had not taken action to reduce the number of same sex accommodation beaches.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 10 (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 9 HSCA (RA) Regulations 2014 Person-centred care Care plans did not always demonstrate the plans were person-centred. The care plans were always given to the patient. This was a breach of Regulation 9 (1)(3)(a)(f)(g).