Humber NHS Foundation Trust

Acute admission wards

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Miranda House	RV945	Avondale Ward	HU3 2RT
Newbridges	RV934	Newbridges	HU2 8TD
Westlands	RV933	Westlands Ward	HU3 5QE
Mill View	RV942	Mill View Court	HU16 5JQ
Buckrose	RV987	Buckrose Ward	Y016 4QP

This report describes our judgement of the quality of care provided within this core service by Humber 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 Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber 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.

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

Contents

Summary of findings

Overall summary

Humber NHS Foundation Trust provides acute inpatient mental health services for adults aged between 18 – 65 years based on five hospital sites.

Overall people who used services told us they felt safe on the acute admission wards. The wards were locked and not all informal users of service knew they had a right to leave.

Ligature points were risk managed. Staff reported incidents electronically and learnt lessons from them. Staff were aware of what to do in relation to safeguarding procedures.

People using services had care plans although there was little evidence of the meaningful involvement of people who use services. For example they were not written in consultation with and in the person's voice and people did not have much awareness of them.

Risk assessments and risk plans were in place. The trust's Recovery Star model was routinely used and people were attending Care Programme Approach (CPA) meetings. Physical health assessments were undertaken and physical health care plans were in place. We found some restrictive practices for people who were not-detained under the MHA. This included taking leave of and lack of access to the internet. There was confusion about what contraband articles could or could not be brought in to the wards.

People spoke positively about the care they received. Staff were clear about their role and purpose and spoke positively about the support they received. There was good multi-disciplinary working. Leadership at ward level and Board level was visible.

Summary of findings

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

Are services safe?
People who used services told us they felt safe on the wards.

Staff knew how to report incidents and how to escalate and report concerns. Staff also managed and assessed risk and were aware of what to do in relation to safeguarding procedures.

The wards were locked to maintain security and not all informal users of service were provided with information or knew they had a right to leave. There was confusion about what the contraband articles were that could not be brought in.

Are services effective?
All the wards had achieved accreditation for inpatient mental health services (AIMS) by the Royal College of Psychiatrists, with Westlands and Newbriges scoring excellent against the standards set.

The service used professional best practice guidelines to provide a standard of service. People's mental and physical health needs were assessed and plans were put in place.

Staff told us they required further training on the Mental Capacity Act. There were practices in place that restricted people, for example access to one of the gardens and access to the internet.

Mental Health Act documentation was completed well.

Are services caring?
People were positive about the care they received and said staff were helpful and supportive. We saw good examples of staff engaging with people.

Potential risk was well managed and people had individual holistic care plans.

Are services responsive to people's needs?
The service had systems in place to ensure that people were involved and informed.

People wrote advanced directives about their future management and community teams attended ward meetings in order to facilitate people's transition back to the community.

Are services well-led?
Staff told us that they knew who the executive team were within the trust although some staff told us they saw little of them with most communication was via email. We saw good examples of ward based leadership.

Summary of findings

Staff had positive relationships with the ward managers and with the modern matrons and received regular supervision and an annual appraisal of their personal development needs. There was good multi-disciplinary working.

Summary of findings

Background to the service

Humber NHS Foundation Trust provides acute inpatient mental health services for adults aged between 18 – 65 years. They are based on five hospital sites

- Avondale is a 14 bedded assessment, treatment and triage service for male and female working age adults. The team works closely with the Crisis Resolution and Home Treatment Services who 'gate keep' admissions.
- Mill View Court is a 10 bedded acute inpatient assessment unit for working age adults.
- Newbridges is a 12 bedded unit that offers assessment and treatment for men with any form of mental illness.
- Westlands is a 16 bedded women only unit that offers assessment and treatment for people with any form of mental illness.
- Buckrose is a 10 bedded unit offering assessment and treatment to adults.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell CEO Oxford Health NHS Foundation Trust

Team Leaders: Surrinder Kaur and Cathy Winn Inspection Managers, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Experts by experience who use services, student nurse, specialist registrar, psychiatrist, nurses, social worker, and occupational therapist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and reviewed care or treatment records of people who use services. We met with people who use services who shared their views and experiences of the core service.

What people who use the provider's services say

Before the inspection, we spoke with people who used the service at focus groups. We looked at surveys undertaken by the trust and we left comments cards at a number of locations.

People told us that generally they felt safe on wards, although we were also told that the atmosphere was often tense and that the case mix, particularly on one ward, could be very volatile. People who use services

usually spoke positively about the care that they received, with some exceptions. People usually knew who their named nurse was and felt involved to some extent in the plans relating to their care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should consider how people in acute admission wards are involved in their care planning consistently across the acute admission wards.
- The trust should ensure that individual restrictions are risk assessed and associated risks are documented and understood by people using services. This includes leave arrangements and access to garden areas.

Humber NHS Foundation Trust

Acute admission wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Avondale Ward	Miranda House
Newbridge Ward	Newbridges
Mill View	Mill View Court
Westlands Ward	Westlands
Buckrose Ward	Buckrose

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.

The use of the Mental Health Act was generally good in the acute admission inpatient wards. The detention documents were available and contained all the required information including the views of the people who use services and the nearest relative as appropriate. Good scrutiny arrangements were in place to ensure the legality of detention documents.

We found that detained people were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in compliance with the Code of Practice. Information on the role of the Independent Mental Health Advocacy service was provided.

We found that section 17 leave was provided in accordance with the Act, with authorised leave recorded.

We found that people's capacity to consent to medication was considered at initial administration or prior to the end of the first three months. Staff knew the legal authority they were administering medication to for detained people that were consenting or non-consenting as the certificates were attached to the medication charts and were being followed. The trust has mechanisms in place to audit this.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff had been given briefings about the Mental Capacity Act (MCA) and DOLS, including guidance on recent case law which had changed the criteria as to what would constitute a Deprivation of Liberty. We were also told that all in-patients had been reassessed against the revised criteria for DOLS and that regular audits were in place to monitor people who might be approaching the threshold for DOLS.

Some staff reported that they required further training in order to routinely meet the expectations of the MCA and DOLS.

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

Summary of findings

People who used services told us they felt safe on the wards.

Staff knew how to report incidents and how to escalate and report concerns. Staff also managed and assessed risk, and were aware of what to do in relation to safeguarding procedures.

The wards were locked to maintain security and not all informal users of service were provided with information or knew they had a right to leave.

Our findings

Miranda House Avondale ward

Track record on safety

We were told by people who used services that generally they felt safe on the ward, although some people said that the mix of people on the ward was at times volatile and that the atmosphere could sometimes be tense.

Staff spoken with were able to describe the electronic system to report incidents and how to complete records on it. Staff described how the information was monitored and how the trust board reviewed incidents and shares lessons in the form of blue light bulletins and information cascaded to discuss during team meetings and supervision.

There have been zero never events reported by the trust between April 2013 and March 2014. There are very few serious incidents that occur on the ward. Between 2012 and March 2014 there were 10 serious incidents that occurred across the whole trust. Staff on Avondale were not aware of any serious incidents that had been reported. The Operational Risk Management Group looked at incidents, safeguards, complaints, deaths. DOLs and identified actions that need to be taken by clinical areas. The Governance Committee looked at the overall all picture and reported to the board.

Learning from incidents and improving safety standards

We looked at the incident recording system that was completed following incidents which allowed staff to review incidents and learn any necessary lessons.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw that the door to the ward was kept locked to prevent entry by anyone not authorised to enter the ward. All visitors to the ward were required to sign in and out at reception to create a record of who was on the ward at any given time.

We found that staff on the ward knew how to manage and report any safeguarding concerns and were able to show us evidence of safeguarding incidents that had occurred on the ward.

Assessing and monitoring safety and risk

We found that a consistent tool was being used to undertake risk assessments which identified the individual risks to a person's safety and wellbeing whilst in hospital. We also saw evidence of coherent risk management plans in response to identified risks.

People told us that it was not clear which items were or were not allowed on the ward. For example mobile phone chargers were not allowed to be retained by people who use services, being described as potential ligature risks, although shoe laces and dressing gown belts were allowed. We could find no evidence of an agreed contraband list for admission wards.

The ward had 14 beds and accommodated both men and women, which was used as an assessment ward. We were told by staff that the ward was routinely full with significant pressure on beds. This meant that often people who use services were admitted directly to one of the treatment wards, rather than receiving an initial period of assessment on Avondale an admission ward which would be more specific than on a treatment ward. This means that the ward had a mixture of acutely ill people with complex needs with people who were more settled therefore having the potential to make the ward more volatile.

Staffing levels for the ward comprised of five staff for the two daytime shifts, with two qualified staff usually on duty.

Are services safe?

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

At night time four staff were on duty with at least one being qualified. We were told that sickness levels were currently manageable and that vacancy levels were very low. Bank staff were occasionally used where additional staff were necessary for increased observation of specific people who use services. On the day of our visit there appeared to be adequate staffing to meet the needs of the people using services.

Understanding and management of foreseeable risk

Environmental risk assessments were being carried out to assess ligature risks and management plans were in place. We did not observe any obvious ligature risks during out tour.

We found that the arrangements for separating men and women to ensure their safety and privacy were adequate, although at the time of the visit the women's lounge was unavailable due to a recent flood. We were told, however, that this was a very temporary deficit. People had free access to their bedrooms.

Many areas of the ward were not clean, We asked to see cleaning rotas and were told that not all were available; however those seen showed gaps in the cleaning schedule.

There were wall mounted alcohol rubs to assist with infection control and staff had access to protective personal equipment such as gloves and aprons.

Newbridges

Track record on safety

We were told by all people who use services that they felt safe on the ward.

CQC inspections in 2012 found the ward to be compliant with outcomes relating to consent to care and treatment, cleanliness and infection control, and complaints.

There have been zero never events reported by the trust between April 2013 and March 2014. There are very few serious incidents that occur on the ward. Staff on Newbridges were not aware of any serious incidents that had been reported. The operational risk management group looked at incidents, safeguards, complaints, deaths. DOLs and identified actions that need to be taken by clinical areas. The governance committee looked at the overall all picture and reported to the board.

Learning from incidents and improving safety standards

We looked at the incident recording system that was completed following incidents which allowed staff to review incidents and learn any necessary lessons. Staff spoken with were able to describe the electronic system and how to complete records on it.

The number of complaints across adult mental health inpatient services was low, the trust complaints log for a 12 month period showed nine complaints in total, three of which were not upheld and two were still being investigated.

Assessing and monitoring safety and risk

We found that a consistent tool was being used to undertake risk assessments which identified the individual risks to a person's safety and wellbeing whilst in hospital, and we also saw evidence of coherent risk management plans in response to identified risks.

We were told that staffing levels for the ward comprised of four staff for the two daytime shifts, with two qualified staff usually on duty. At night time three staff were on duty with one being qualified. We were told that sickness levels were currently manageable and that vacancy levels were very low. Bank staff were occasionally used where additional staff were necessary for increased observation of specific people who use services. The trust monitors bank and agency usage. We looked at one quarter's results and it showed that there were 128 shifts that had been covered by bank or agency staff and 26 shifts could not be covered by bank or agency, this meant that managers had to risk assess and deploy staff if necessary from other areas.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse.

We saw that the door to the ward was kept locked to prevent entry by anyone not authorised to enter the ward. All visitors to the ward were required to sign in and out at reception to create a record of who was on the ward at any given time.

We found that staff on the ward knew how to manage and report any safeguarding concerns and were able to show us evidence of safeguarding incidents that had occurred on the ward.

Are services safe?

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

Understanding and management of foreseeable risk

We were told by staff that the ward was routinely full with pressure on beds. The ward had 12 beds to accommodate men from both Hull and the East Riding, and was used as a treatment ward. There were plans by the trust to increase the number of beds to 18 later in the year, and preparatory work to enable this was well advanced.

Environmental risk audits were undertaken and management plans were in place. Most ligature risks around the ward had been eliminated and those that remained were risk managed by staff.

All areas of the ward were clean and tidy and we were told by staff that the cleaning service was consistently good. Although space was limited on the ward good use had been made of the available space. There were wall mounted alcohol rubs to assist with infection control and staff had access to protective personal equipment such as gloves and aprons.

Westlands

Track record on safety

We were told by all people who use services interviewed that they felt safe on the ward with statement like “feels really safe, there are plenty of people to go to”.

Environmental audits were undertaken and risk management plans were in place. We saw that there were systems to identify and manage potential ligature risks. Most ligature risks around the ward had been eliminated and those that remained were risk managed by staff. For example there was a traditional bed in one room and people who occupied it were risk assessed prior to being placed there which became part of the individual’s care plan.

Learning from incidents and improving safety standards

We looked at the incident recording system that was completed following incidents which allowed staff to review incidents and learn any necessary lessons. Staff spoken with were able to describe the electronic system and how to complete records on it.

Staff told us that there had been a cluster of serious untoward incidents (SUIs) in the last year that had been examined and changes made to minimise the possibility of re-occurrence. For example a new processes had been put in place to prevent ‘tail-gating’ ie people following someone at the exit door.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had received training in safeguarding practices. We found that staff on the ward knew how to manage and report any safeguarding concerns and were able to show us evidence of examples of safeguarding incidents that had occurred on the ward , how they been identified and managed.

Assessing and monitoring safety and risk

We found that a consistent tool was being used to undertake risk assessments which identified the individual risks to a person’s safety and wellbeing whilst in hospital, and we also saw evidence of coherent risk management plans in response to identified risks.

The ward had 16 beds to accommodate women from both Hull and the East Riding, and was used as a treatment ward. We were told by staff that the ward was routinely full with pressure on beds and that over the previous weekend two leave beds had been taken up by new admissions. The ward manager told us that they did not accept women in late pregnancy to minimise risk, and that they used the community perinatal service to monitor the well-being of these women.

We were also told that adolescents were occasionally admitted to the ward in emergency situations, and that there had been three such admissions already this year. However, we were told that the CAMHS team provided additional support to younger people who were admitted, and we found that such people who used services were transferred to more appropriate settings quickly.

Staffing levels for the ward comprised of five staff for the two daytime shifts, with two qualified staff usually on duty. At night time three staff were on duty with one being qualified. We were told that sickness levels were ‘reasonable’ and that vacancy levels were very low with only one vacancy currently. Bank staff were occasionally used where additional staff were necessary for people who needed an increased level of observation. The staffing levels appeared to be adequate for the dependency levels on the ward on the day of our inspection. The trust monitored staffing levels. Its register for one quarter

Are services safe?

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

showed that 92 shifts on the ward were covered by bank and agency and that 22 shifts could not be covered, managers were supportive and assessed the situation using cover from other wards if necessary.

We saw that the door to the ward was kept locked to prevent entry by anyone not authorised to enter the ward. All visitors to the ward were required to sign in and out at reception to create a record of who was on the ward at any given time.

Understanding and management of foreseeable risk

All areas of the ward were clean and tidy and we were told by staff that the cleaning service was consistently good. There were wall mounted alcohol rubs to assist with infection control and staff had access to protective personal equipment such as gloves and aprons.

People told us that there was no clear guidance about the list of items that were considered contraband.

Mill View Court

Track record on safety

There had been zero never events reported by the trust between April 2013 and March 2014. There were very few serious incidents that occurred on the ward. Between 2012 and March 2014 there were 10 serious incidents that occurred across the whole trust. Staff on Millview were not aware of any serious incidents that had been reported. The operational risk management group looked at incidents, safeguards, complaints, deaths. DOLs and identified actions that need to be taken by clinical areas. The governance committee looked at the overall all picture and reported to the board

Learning from incidents and improving safety standards

The ward regularly received feedback from the trust's weekly risk management meeting, but were not aware of the "Lessons learned" newsletter that we were informed was in place. The ward received blue light alerts and discusses these at team meetings.

We reviewed the incident recording system (Datix) that was completed following incidents which allowed staff to review incidents and learn any necessary lessons. Staff spoken with were able to describe the electronic system and how to complete records on it.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found that staff on the ward knew how to manage and report any safeguarding concerns and were able to show us evidence of safeguarding incidents that had occurred on the ward. A safeguarding incident was identified during the recovery planning meeting and was immediately addressed. We found safeguarding to be embedded in staff's practice.

Assessing and monitoring safety and risk

All people who use services have detailed initial assessments, risk assessments and these were carried out under the trust's Recovery Star model of care and treatment.

We found that a consistent tool was being used to undertake risk assessments which identified the individual risks to a person's safety and well-being whilst in hospital. We also saw evidence of coherent risk management plans in response to identified risks.

The ward had 10 beds and accommodated both men and women. The ward was used as an admission and treatment ward. We found that the arrangements for accommodating both men and women safely were in place. The ward had a mixed lounge and a separate small lounge for women who use services. All bedrooms were single with en-suite facilities.

The trust monitored the number of bank and agency shifts covered on Mill View Court, in one quarter period 579 shifts were covered by bank and agency staff and demonstrated all shifts were covered.

Understanding and management of foreseeable risk

We saw that the door to the ward was kept locked to prevent entry by anyone not authorised to enter the ward. All visitors to the ward were required to sign in and out at reception to create a record of who was on the ward at any given time. However, this meant that people who use services who were not detained were managed in the same way as those who were detained under the Mental Health Act (MHA) by being cared for in a locked ward. We found that staff were unaware that this was a restrictive practice and on discussion, they agreed they would review this issue.

Are services safe?

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

People using services on the ward told us they felt mainly safe, however could feel vulnerable on the ward, due to the mix of people who use services who are ill and people who use services with drug and alcohol problems.

All areas of the ward were clean. There were wall mounted alcohol rubs to assist with infection control and staff had access to protective personal equipment such as gloves and aprons.

The ward has an acting ward manager. The ward was staffed with a combination of qualified nurses and healthcare assistants.

Buckrose

Track record on safety

There had been zero never events reported by the trust between April 2013 and March 2014. There are very few serious incidents that occur on the ward. Between 2012 and March 2014 there were 10 serious incidents that occurred across the whole trust. Staff on Buckrose were not aware of any serious incidents that had been reported. The operational risk management group looked at incidents, safeguards, complaints, deaths. DOLs and identified actions that need to be taken by clinical areas. The governance committee looked at the overall all picture and reported to the Board

Learning from incidents and improving safety standards

The ward regularly received feedback from the trust's weekly risk management meeting, but staff told us that they were not aware of the "Lessons learned" newsletter. The ward staff received blue light alerts and discussed the implications of these at team meetings.

We reviewed the incident recording system (Datix) that was completed following incidents which allowed staff to review incidents and learn any necessary lessons. Staff spoken with were able to describe the electronic system and how to complete records on it.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found that staff on the ward knew how to manage and report any safeguarding concerns and were able to show us evidence of safeguarding incidents that had occurred on the ward.

Assessing and monitoring safety and risk

We found that a consistent tool was being used to undertake risk assessments which identified the individual risks to a person's safety and wellbeing whilst in hospital, and we also saw evidence of coherent risk management plans in response to identified risks.

The trust monitored the number of shifts covered by bank and agency staff. For Buckrose ward 352 shifts were covered in a quarter period and 12 shifts could not be covered. Where shifts could not be covered, managers assessed the situation and if necessary deployed staff from other areas.

Understanding and management of foreseeable risk

We were told by people who use services that they felt safe on the ward. We saw that the door to the ward was kept locked to prevent entry by anyone not authorised to enter the ward. All visitors to the ward were required to sign in and out at reception to create a record of who was on the ward at any given time. However, this meant that people who use services who were informal were managed in the same way as those who were detained under the Mental Health Act (MHA) by being cared for in a locked ward.

All areas of the ward were clean. There were wall mounted alcohol rubs to assist with infection control and staff had access to protective personal equipment such as gloves and aprons.

The ward had 6 beds and accommodated both men and women as a treatment ward. We found that the arrangements for caring for men and women to protect their safety and privacy and dignity was good. The ward had a mixed lounge and a separate small lounge for women to use.

The reduction in bed numbers has meant that the four bed dormitories were no longer shared and all people who use services had individual bedrooms.

The ward had a new acting ward manager who took up post in March 2014. We were told that the staffing team for the ward consisted of six substantive qualified nurses and three healthcare assistants with the acting ward manager being supernumerary. We were told that the staff team juggled their time between inpatient services and carrying out duties as part of the Home Intensive Treatment Service (HITT). Bank staff were regularly used where additional staff were necessary.

Are services safe?

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

The trust reported that there were challenges in recruitment to the area and they were actively trying to recruit staff. We were told the bank staff were a long term provision to enable wards to have a full complement of staff and to provide 1; 1 observations. Bank staff on duty confirmed this to be the case.

Are services effective?

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.

Summary of findings

The service used professional best practice guidelines to provide a standard of service. People's mental and physical health needs were assessed and plans were put in place.

However staff told us they required further training on the Mental Capacity Act and there were practices in place that restricted people, for example access to one of the gardens and access to the internet.

Mental Health Act documentation was completed well.

Our findings

Miranda House Avondale ward

Assessment and delivery of care and treatment

Care plans were holistic and individualised in their approach to reflect people's needs. We saw evidence that formal care programme approach meetings were held and were told that these were usually arranged within the first seven days after someone was admitted.

We looked at notes and found good evidence of the assessment of peoples' capacity to consent to treatment through the use of a helpful proforma that was routinely well completed.

We found that all people who use services had a thorough physical assessment completed by a doctor on admission and that any on-going physical health needs were appropriately followed up by staff. Where physical health needs were present these were appropriately addressed within care plans.

We asked staff about specific training related to the Mental Capacity Act and the Deprivation of Liberty Safeguards they had received. Staff told us that, they had received a briefing, but it was an area that further training would be helpful.

Outcomes for people using services

We found evidence that staff's knowledge and awareness of policy and practice guidance relating to their work was present and utilised.

The ward had achieved AIMS accreditation with the Royal College of Psychiatrists which demonstrated that they had met quality standards set.

Staff equipment and facilities

Staff told us that they had completed and were up to date with their mandatory training and that only rarely would they be held back from attending training due to pressure on the ward. Staff did say that many of the mandatory training programmes were relatively brief but held at trust headquarters, which necessitated significant travelling time. Staff suggested that providing training at a local level would serve to minimise the release time necessary for staff to attend. Staff members also told us that training to support their development was also available. This meant that staff should have the necessary skills and competency to care for people's needs.

We were also told that regular reflective practice meetings were held for staff at ward level, which were helpful in terms of coping on a day to day basis with a busy assessment ward. Staff received regular supervision.

Access to meaningful activities

Although some activities were made available to people who use services, some said that it was boring on the ward and there was not enough to do. None of the people who use services had access to the internet or a computer which some said would be very helpful. We saw activity timetables; people reported that there were few activities at weekends. Staff reported that because people were very ill the uptake of activities was not good.

Multidisciplinary working and multi-agency working

Daily multi-disciplinary meetings were held on the ward to ensure that initial assessments were completed soon after admission. We spoke to a pharmacist who worked closely with doctors, nurses and people who use services on the ward and provided a helpful service to ensure that appropriate medication regimes were in place, and that people who use services understood the purpose and likely side effects of medication they were taking.

Staff knew who the safeguarding contacts were and how to involve them when there were concerns.

The ward had daily consultant cover as well as junior doctors, and sometimes student nurses on placement from the university.

Are services effective?

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.

Mental Health Act

We found that there were effective systems and processes in place to manage the admission of detained people who use services under the Mental Health Act. The detention documents were available and contained all the required information including the views of the people who use services and the nearest relative as appropriate. Good scrutiny arrangements were in place to ensure the legality of detention documents.

We found that section 17 leave was provided in accordance with the Act, Forms were completed appropriately in terms of the level of detail relating to conditions and frequency.

We found capacity to consent to medication at initial administration or prior to the end of the first three months. We also found appropriate completed certificates of treatment for consenting and non-consenting detained people, and that only authorised medication was being administered.

We found that detained people were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in compliance with the Code of Practice. Information on the role of the Independent Mental Health Advocacy service was provided.

We found that that information about the CQC and how to make contact with us was displayed on notices boards for people to read.

Newbridges

Assessment and delivery of care and treatment

We found care plans were holistic and individualised in their approach with evidence that people had been involved in the process, and were aware of the content of their own care plans.

The Recovery Star tool was routinely used to enable people to measure their recovery progress and link in to care planning although this was not consistently evident. Documentation relating to care planning was reasonably completed and was usually signed by people who use services. We found evidence of formal care programme approach meetings and regular planned review meetings, with evidence of serious attempts to engage people who use services in reviews.

We looked at notes and found good evidence of the assessment of people who use services ' capacity to consent to treatment through the use of a helpful proforma that was routinely well completed.

We found that all people who use services had a thorough physical assessment completed by a doctor on admission and that any on-going physical health needs were appropriately followed up by staff. Where physical health needs were present these were appropriately addressed within care plans.

Outcomes for people using services

We followed the care and treatment of some of the people on the ward. It was clear from discussions with staff and reading of the records available, that care being provided was both holistic and individualised to reflect the person's needs.

People we spoke with, gave very positive views as to their experience on the ward. People on the ward who were not detained under the Act, told us that they knew they had a right to leave if they so wished and that staff would accommodate this if they were asked to.

Newbridges received an excellent score in its accreditation of inpatient mental health services (AIMS) from the Royal College of Psychiatrists, demonstrating the commitment to quality improvement by peer review.

Staff equipment and facilities

We found that staff were, in the main, clear about their purpose and function and able to tolerate the pressures faced, through mutual support and a commitment to the care of people who use services.

Staff told us that they had completed and were up to date with their mandatory training and that only rarely would they be held back from attending training due to pressure on the ward. Staff did say that many of the mandatory training programmes were relatively brief but held at trust Headquarters, which necessitated significant travelling time. Staff suggested that providing training at a local level would serve to minimise the release time necessary for staff to attend. Staff members also told us that training to support their development was also available.

We asked about specific training related to the Mental Capacity Act and the Deprivation of Liberty Safeguards, and were told that whilst briefings had been provided to staff, it was an area that further training would be helpful.

Are services effective?

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.

We were also told that regular reflective practice meetings were held at ward level, which were helpful in terms of coping on what is a busy treatment ward.

Staff spoken with were able to demonstrate that their knowledge and awareness of policy and practice guidance relating to their work was up to date and they used this in their day to day role on the ward.

Access to meaningful activities

There were activity timetables on the ward. We were told that a full time associate practitioner occupational therapist and another part time occupational therapist were attached to the ward None of the people who use services had access to the internet or a computer which some said would be very helpful. People reported that there were not enough activities especially at weekends.

Multidisciplinary working and multi-agency working

In terms of input from psychology, we were told that there was one full time psychologist who worked across all five acute wards within the trust but that long-term leave was being taken with no cover arrangements in place. Whilst this service was appreciated by staff it was felt to be a stretched resource.

We were told by staff that a pharmacist worked closely with doctors, nurses and people who use services on the ward and provided a helpful service to ensure that appropriate medication regimes were in place, and that people who use services understood the purpose and likely side effects of medication they were taking.

Mental Health Act

We found that there were effective systems and processes in place to manage the admission of detained people who use services under the Mental Health Act. The detention documents were available and contained all the required information including the views of the people who use services and the nearest relative as appropriate. Good scrutiny arrangements were in place to ensure the legality of detention documents.

We found that section 17 leave was provided in accordance with the Act, Forms were completed appropriately in terms of the level of detail relating to conditions and frequency.

We found capacity to consent to medication at initial administration or prior to the end of the first three months. We also found appropriate certificates for treatment for consenting and non-consenting detained people and that only authorised medication was being administered.

We found that detained people were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in compliance with the Code of Practice.

Information on the role of the Independent Mental Health Advocacy service was provided.

Westlands

Assessment and delivery of care and treatment

We found care plans were holistic and individualised in their approach with evidence that people who use services had been involved in the process, and were aware of the content of care plans relating to them. The Recovery Star was also routinely being used to facilitate the engagement of people who use services in care planning. Documentation relating to care planning was reasonably completed and was usually signed by people who use services. We found evidence of formal care programme approach meetings and regular planned review meetings, with evidence of serious attempts to engage people who use services in reviews. We also found evidence of the positive involvement of carers in a person's care.

We looked at notes and found good evidence of the assessment of people who use services ' capacity to consent to treatment through the use of a helpful proforma that was routinely well completed.

We found that everyone had a thorough physical assessment completed by a doctor on admission and that any on-going physical health needs were appropriately followed up by staff. All people who use services had a 'Health Improvement Profile' completed and incorporated into care plans.

Where physical health needs were present these were appropriately addressed within care plans.

Outcomes for people using services

We followed the care and treatment of some of the people on the ward. It was clear from discussions with staff and the examination of notes that care being provided was both holistic and individualised.

Are services effective?

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.

People who use services interviewed gave very positive views as to their experience on the ward.

Westlands received an excellent score in its accreditation of inpatient mental health services (AIMS) from the Royal College of Psychiatrists, demonstrating the commitment to quality improvement by peer review.

Staff equipment and facilities

Staff told us that they had completed and were up to date with their mandatory training and that only rarely would they be held back from attending training due to pressure on the ward. Staff members also told us that training to support their development was also available.

We asked about specific training related to the Mental Capacity Act and the Deprivation of Liberty Safeguards, and were told that whilst briefing had been provided to staff, it was an area that further training would be helpful.

Staff had fortnightly reflective practice with a psychologist to consider their role and performance.

Access to meaningful activities

We were told that a full time occupational therapist were attached to the ward. They undertook assessments and kept records of participation. People told us that they would like more activities especially at the weekends.

Multidisciplinary working and multi-agency working

In terms of input from psychology we were told that there is one full time psychologist who worked across all five acute wards within the trust, however due to long term leave, with no cover

arrangements in place was a stretched resource.

We were told by staff that a pharmacist worked closely with doctors, nurses and people who use services on the ward and provided a helpful service to ensure that appropriate medication regimes were in place, and that people who use services understood the purpose and likely side effects of medication they were taking.

Mental Health Act

We looked at files associated with all currently detained people who use services and found evidence of the routine and regular explanation to people who use services their rights.

We found that there were effective systems and processes in place to manage the admission of detained people who use services under the Mental Health Act. The detention documents were available and contained all the required information including the views of the people who use services and the nearest relative as appropriate. Good scrutiny arrangements were in place to ensure the legality of detention documents.

We found that section 17 leave was provided in accordance with the Act, Forms were completed appropriately in terms of the level of detail relating to conditions and frequency.

We found capacity to consent to medication at initial administration or prior to the end of the first three months. We also found appropriate certificates of treatment for people consenting or non consenting to their medication, and that only authorised medication was being administered.

Information on the role of the Independent Mental Health Advocacy service was provided.

Mill View Court

Assessment and delivery of care and treatment

We found care plans were holistic and individualised in their approach with some evidence that people who use services had been involved in the process, although meaningful involvement was not consistently applied. The Recovery Star tool was routinely used to enable people to measure their recovery progress and link in to care planning although this was not consistently linked to care plans. Documentation relating to care planning was reasonably completed and was occasionally signed by people who use services; however it records did not indicate why people may have refused to sign their care plans.

We attended the recovery planning meeting and observed risk assessments being devised, reviewed and evaluated with risk management plans being developed. Discussions included feedback on the service users' presentation, medication, GRIST risk assessment, Care Programme Approach (CPA), discharge planning, physical health, capacity and consent to treatment, safeguarding, coping skills, accommodation, family involvement, advocacy, observations and leave arrangements.

People's involvement in their care planning was evident during the recovery planning meeting where one service user had written his response to the previous plans devised at the previous meeting and had asked that his comments

Are services effective?

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.

be read out at the meeting. We found evidence of formal care programme approach meetings and were told that these were usually arranged within the first seven days after a person being admitted.

We looked at notes and found good evidence of the assessment of people who use services '

capacity to consent to treatment through the use of a helpful proforma that was routinely well completed. We found that all people who use services had a thorough physical assessment completed by a doctor on admission and that any on-going physical health needs were appropriately followed up by staff. Where physical health needs were present these were appropriately addressed within care plans. People who use services told us that the staff had discussed their medication with them and that they had been provided with a leaflet about the medications they were prescribed.

Outcomes for people using services

People who use services told us they saw their doctor frequently and that they could approach them at any time. People who use services knew who their keyworkers were and felt comfortable in approaching them.

A detained person due to go on leave from the ward told us that they had met the Crisis team on the ward and knew that they were going to support him during his trial period at home.

We found the ward to be a locked ward and people have to request access and egress through staff. Staff said that they explain this to all people who use services on admission and repeat this as required. It was also explained in the welcome pack given to each person on admission.

Staff equipment and facilities

Staff told us that they had completed and were up to date with their mandatory training and that only rarely would they be held back from attending training due to pressure on the ward. We were also told that regular reflective practice meetings were held at ward level facilitated by the ward psychologist and the nurse consultant.

We asked about specific training related to the Mental Capacity Act and the Deprivation of Liberty Safeguards, and were told that whilst briefing had been provided to staff, it was an area that further training would be helpful.

We found evidence that members of staff's knowledge and awareness of policy and practice guidance relating to their work was present and utilised.

Staff were clear on which people who use services were detained under the Mental Health Act

Access to meaningful activities

Most people who use services we spoke with told us that staff were helpful but expressed feelings of being bored and that there could be more activities.

Multidisciplinary working and multi-agency working

The ward operated as a multi-disciplinary team, with input from the modern matron, a consultant psychiatrist and the nurse consultant. The trust is a teaching trust and we met a GP trainee on placement. We attended the recovery planning meeting and this was attended by a number of qualified nurses who the identified key worker were people who use services, the consultant psychiatrist, the GP trainee, a pharmacist, psychologist, occupational therapist and members of the community home treatment teams. There was evidence of clear communication between all disciplines and the integration of the community teams.

The recovery planning meeting was held weekly, with all the multi-disciplinary team in attendance to review people who use services care, treatment and recovery.

Mental Health Act

We found that there were effective systems and processes in place to manage the admission of detained people who use services under the Mental Health Act. The detention documents were available and contained all the required information including the views of the people who use services and the nearest relative as appropriate. Good scrutiny arrangements were in place to ensure the legality of detention documents.

We found that section 17 leave was provided in accordance with the Act, Forms were completed appropriately in terms of the level of detail relating to conditions and frequency.

We found capacity to consent to medication at initial administration or prior to the end of the first three months. We also found appropriate certificates of treatment for consenting and non-consenting detained people, and that only authorised medication was being administered.

Are services effective?

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.

We found that people detained under the MHA were provided with information on their rights at first admission and on subsequent occasions in compliance with the Code of Practice. Information on the role of the Independent Mental Health Advocacy service was provided.

Buckrose

Assessment and delivery of care and treatment

We found care plans were holistic and individualised in their approach with some evidence that people who use services had been involved in the process, although meaningful involvement was not consistently applied in terms of using the user voice and reflecting their views.

We found evidence of formal care programme approach meetings and were told that these were usually arranged within the first seven days after a person was admitted.

We looked at notes and found evidence of the assessment of people who use services ' capacity to consent to treatment through the use of a helpful proforma that was routinely well completed.

Outcomes for people using services

We found that all people who use services had a thorough physical assessment completed by a doctor on admission and that any on-going physical health needs were appropriately followed up by staff. Where physical health needs were present these were appropriately addressed within care plans.

The Recovery Star was also routinely being used to enable people who use services to plot the progress they were making.

Section 17 leave forms were being appropriately completed for detained people who use services but people not detained under the Mental Health Act reported a restrictive regime.

Staff equipment and facilities

We asked about specific training related to the Mental Capacity Act and the Deprivation of Liberty Safeguards, and were told that whilst briefing had been provided to staff, it was an area that further training would be helpful.

We were also told that regular reflective practice meetings were held at ward level.

We found evidence that staff's knowledge and awareness of policy and practice guidance relating to their work was present and utilised.

Staff told us that they had completed and were up to date with their mandatory training and that only rarely would they be held back from attending training due to pressure on the ward.

Access to meaningful activities

Wards had activity timetables and people had access to occupational therapy for activities of daily living such as cooking, and also psychologist support. Some people who use services reported feeling bored and stated "there could be more activities" and that the ward furniture was uncomfortable. .

Multidisciplinary working and multi-agency working

Additional multi-disciplinary team members included input from an occupational therapist 30 hours a week, psychology input one day a week, a Consultant Psychiatrist who provides cover to both the inpatient service and the HITT, as well as a junior doctor three days a week, shared with Westlands acute admission ward in Hull. The trust's out of hours on call medical cover was in place but there could be delays in doctors visiting the ward due to the geographical location of Buckrose ward. We observed the involvement and input from the occupational therapist.

Mental Health Act

We found that there were effective systems and processes in place to manage the admission of detained people who use services under the Mental Health Act. The detention documents were available and contained all the required information including the views of the people who use services and the nearest relative as appropriate. Good scrutiny arrangements were in place to ensure the legality of detention documents.

We found that section 17 leave was provided in accordance with the Act, with a reasonable form in use to record authorised leave, and appropriate completion of forms, in terms of the level of detail relating to conditions and frequency.

We found capacity to consent to medication at initial administration or prior to the end of the first three months. We also found appropriate certificates of treatment for consenting and non-consenting detained people, and that only authorised medication was being administered.

Are services effective?

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.

We found that detained people were being provided with information on their rights under the Mental Health Act at first admission and on subsequent occasions in compliance with the Code of Practice.

Information on the role of the Independent Mental Health Advocacy service was provided.

Are services caring?

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

Summary of findings

People were positive about the care they received and said staff were helpful and supportive. We saw good examples of staff engaging with people. Potential risk was well managed and people had individual holistic care plans.

Our findings

Miranda House Avondale ward

Kindness, dignity and respect

Most people we spoke with told us that staff were helpful although often very busy which limited their availability. One person said to us that "staff were warm and supportive" whilst another person said that "nothing could have been done better". However, one person spoken with said that some staff members were 'not interested in her'. A number of people who use services commented that there had been a significant number of disturbances on the ward which had unsettled them.

The interactions we saw between staff and people who use services was positive with staff being demonstrating patience and explaining difficult situations to people who use services calmly. Most staff was observed to be out in the ward area engaging with people who use services.

We checked people's care plan records and found that plans were in place which reflected the individual needs of people who use services.

We found that people had care plans in place that were individualised and holistic. A useful risk assessment tool was routinely in use and well completed.

We followed the care and treatment of some of the people on the ward and also spoke to people who had previously been on the ward and were currently in the care of the Crisis Teams. It was clear that the ward, in providing an initial assessment service, often admitted people who were who are acutely ill with complex needs. This volatile mix of people unsettled and settled living on the same ward, was raised by a number of people who use services as a concern. We saw records that a number of incidents had occurred. This means that the ambiance of the ward could be affected and impact on people's experience.

People spoken with gave us very mixed views as to their experience on the ward, with some providing a negative view and others reporting a much more positive experience.

People using services involvement

The ward had a welcome pack for newly admitted people who use services which gave appropriate information regarding their stay on the ward. We noticed that a range of appropriate information was located on walls in the ward area, where people who use services could access it.

We saw some evidence that people had been involved in the care planning process, although meaningful involvement was not consistently applied in that the care plans were not written in the person's voice and did not consistently record their views.

Documentation relating to care planning was reasonably completed and was occasionally signed by people who use services, it was not consistently recorded if people had refused to sign their care plans. However, some people who use services told us they did not know they had a care plan, had not been involved in its development and did not want a copy of their care plan.

The Recovery Star was also routinely being used to facilitate the engagement of people who use services in care planning it is a tool for people using services to enable them to measure their own recovery progress with the help of staff.

Emotional support for care and treatment

We saw records that demonstrated involvement of carers in care planning meetings. Care plans showed a strong focus on recovery and there were clear plans around people's eventual discharge.

Newbridges

Kindness, dignity and respect

We spent time on the ward observing the care offered to people and staff's attitude and manner.

All the people we spoke with were very positive about the care they had received and the response they got from staff who, they said consistently treated them with respect. One person who had been an in-patient in a variety of settings said that the ward was the best place he had been in, stating that he had "never met a system that is so relaxed, it helps the people who use services relax".

Are services caring?

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

People told us that staff were good at anticipating their needs and taking them to one side before things got difficult. Staff spoke very positively about their employment, and of their management within the trust. Many staff had worked for the trust for lengthy periods and were committed to the organisation. We found that staff were, in the main, clear about their purpose and function and able to tolerate the pressures faced, through mutual support and a commitment to the care of people who use services. The interactions we saw between staff and people who use services were positive with staff being approachable and patient. Most staff were observed to be out in the ward area engaging with people who use services.

People using services involvement

We also found evidence of the routine use of the 'Recovery Star' to facilitate people's engagement in their personal care planning.

The ward had a welcome pack for newly admitted people who use services which gave appropriate information regarding their stay on the ward. We noticed that an excellent range of appropriate information was located on walls in the ward area, where people who use services could access it.

Emotional support for care and treatment

We observed records that demonstrated involve carers in care planning meetings, Care plans did show a strong focus on recovery and also had clear plans around the eventual discharge of people.

Westlands Ward

Kindness, dignity and respect

All the people we spoke with were very positive about the care they had received and the response they got from staff, who, they said, consistently treated them with respect. One person said that "the staff are brilliant" and another said that "if they are busy they will come and find you".

The interactions we saw between staff and people who use services, was positive. Staff were approachable and patient. Most staff were observed to be out of the staff office and in the ward area engaging with people who use services.

People who use services told us of their frustration that bedrooms were kept locked which meant that they were unable to access them during the day.

All people who use services had their own individual bedrooms and these were reasonably furnished and decorated. However people who use services told us that their rooms were kept locked during the day preventing them having access and that their rooms had no lockable space in which to keep valuable items.

People who use services were able to have access to an area to prepare hot drinks whenever they wanted to. None of the people who use services had access to the internet or a computer which some said would be very helpful.

Informal people who use services also felt aggrieved about restrictions on the leave they were able to take. We found leave forms were in place for informal people similarly to s17 leave forms for detained people. This was highlighted as restrictive practice for informal people using services. The trust was responsive by informing the clinical teams and ceased the practice.

People who use services also said that one to one sessions with their named nurse was often cancelled as staff were too busy.

People using services involvement

The ward had a welcome pack for newly admitted people who use services which gave appropriate information regarding their stay on the ward. We noticed that an excellent range of appropriate information was located on walls in the ward area, where people who use services could access it.

We also found evidence of the routine use of the 'Recovery Star' to facilitate peoples engagement in care planning. A useful risk assessment tool was routinely in use and well completed.

Emotional support for care and treatment

We found evidence of the positive involvement of carers in the care of their relatives. We found that people had care plans in place that were individualised and holistic.

Mill View Court

Kindness, dignity and respect

The interactions we saw between staff and people who use services were positive. Most staff were observed to be out in the ward area engaging with people who use services. Where people were distressed they were supported by staff in a professional and caring manner.

One person spoken with told us staff were caring and that "they do their best to get you back on track, and this is

Are services caring?

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

proved as I am going home". Another person told us that he had had a difficult experience recently and had been able to approach his key worker and action was taken to protect him.

One person described an incident where he behaved "oddly" and had not been treated particularly well, however, they had discussed this with their key worker and all matters had been addressed.

People using services involvement

We found that people had care plans in place that were individualised to meet their needs and holistic. We also found evidence of the routine use of the Recovery Star to facilitate people who use services engagement in their progress and care planning. A risk assessment tool (GRIST) was routinely in use and well completed. We evidenced this through discussions with people who use services, attendance at the recovery planning meeting and a review of people who use services' records.

The ward had a welcome pack for newly admitted people who use services which gave appropriate information regarding their stay on the ward. We noticed that a range of appropriate information was located on walls in the ward area, where people who use services could access it.

Emotional support for care and treatment

We checked people's care plan records and found that plans were in place which reflected the individual needs of people who use services. We observed records that demonstrated involvement carers in care planning meetings, Care plans did show a strong focus on recovery and also had clear plans around the eventual discharge of people.

Buckrose

Kindness, dignity and respect

People spoken with gave very mixed views as to their experience on the ward, with some providing a negative view and others reporting a much more positive experience.

The interactions we saw between staff and people who use services was positive. Most staff were observed to be out in the ward area engaging with people who use services.

Information available

Most people we spoke with told us that staff were helpful. One person reported "staff help you to have an open room to clear your head".

One person said "nothing could be improved". People who use services said they felt safe on the ward. People who use services said the care was good.

We found that people had care plans in place that were individualised and holistic. We also found evidence of the routine use of the Recovery Star to facilitate people's engagement in care planning.

People using services involvement

The ward had a welcome pack for newly admitted people who use services which gave appropriate information regarding their stay on the ward. We noticed that a range of appropriate information was located on walls in the ward area, where people who use services could access it.

Emotional support for care and treatment

People who use services told us that the community teams that were to provide them with support on discharge regularly visited them on the ward prior to discharge.

We checked people's care plan records and found that plans were in place which reflected the individual needs of people who use services and their emotional support needs.

Are services responsive to people's needs?

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

Summary of findings

The service had systems in place to ensure that people were involved and informed.

People wrote advanced directives about their future management and community teams attended meetings in order to facilitate people's transition back to the community.

Our findings

Miranda House Avondale ward

Planning and delivery

Daily planning meetings enabled the staff team to respond to peoples identified needs. The team aimed to assemble a coherent care plan within seven days taking into account individual emotional and cultural needs.

All people who use services had their own individual bedrooms and these were reasonably furnished and decorated, although "grubby". Three beds in the centre of the ward could be made available to either men or women giving a greater degree of flexibility, depending on demand.

People who use services also expressed their frustration that although three garden areas were located adjacent to the ward, they were only allowed free access to one of them, as access and egress was controlled by staff. People told us that this was because the walls on the other two gardens were said to be too low.

The garden was used by smokers and non-smokers as there was no smoke free area.

Accommodation for men and women was planned for with male and female rooms in separate corridors with separate facilities such as toilets and lounges. The women's lounge was out of commission at the time of the visit but we were told that this was temporary.

People's independence was reflected in that people who use services were able to have access to an area to prepare hot drinks whenever they wanted to.

Right care at the right time

We found that community teams worked usually closely with the ward and attended planning meetings but that pressure on capacity in some of the teams was serving to hinder these positive working relationships, and that some people who use services discharge was being delayed as a consequence of this. A daily professionals meeting took place on the ward to ensure that assessments were proceeding in a timely manner.

There is one full time Psychologist who worked across all five acute wards within the trust however was on long term leave. A psychologist was available to cover if required.

People who use services who were not detained by the Act, reported a restrictive regime which they felt should not apply to them. We saw that the door to the ward was kept locked to prevent entry by anyone not authorised to enter the ward. All visitors to the ward were required to sign in and out at reception to create a record of who was on the ward at any given time. However, this

meant that people who use services who were not detained were managed in the same way as those who were detained under the Mental Health Act (MHA) by being cared for in a locked ward. We found that staff were unaware that this was a restrictive practice and on discussion, they agreed they would review this issue.

Care Pathway

Although feedback from people who use services was mixed the prevailing view was positive, with one person stating that "overall I think this is a good service. I've had no problems really".

We saw evidence that people who use services were encouraged to consider the benefits of establishing advanced directives and were supported to do this. Some people who use services indicated that there was a problem in accessing necessary medication if admitted over the weekend.

The model of care intended was for people to be admitted on to the admission wards and then to proceed to the treatment wards and or into the care of community mental health teams. Whilst it was not the case during our visit staff reported that sometimes people came directly to the treatment wards because the admission wards were full. Discharges could be delayed due to capacity issues within the community teams. The trust has a risk register which identifies capacity issues in community teams and have action plans in place.

Staff had equality and diversity training.

Are services responsive to people's needs?

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

Complaints

We saw evidence of a daily focus group meeting with people who use services and staff, and also of issues that people who use services had raised being picked up by staff and either resolving, or explaining why a desired outcome wasn't feasible. Staff were able to explain the complaints process and were informed of the outcome to assist learning for improvement. The number of complaints across adult mental health inpatient services was low, the trust complaints log for a 12 month period showed nine complaints in total, three of which were not upheld and two were still being investigated.

Newbridges

Planning and delivery

All people who use services had their own individual bedrooms and these were reasonably furnished and decorated.

People who use services were able to have access to an area to prepare hot drinks whenever they wanted to.

We saw evidence that people who use services were encouraged to consider the benefits of establishing advanced directives and were supported to do this.

Right care at the right time

Feedback from people who use services interviewed was universally positive about the behaviour and attitude of staff and the general quality of their care on the ward.

Care Pathway

We found that community teams worked usually closely with the ward and attended planning meetings but that pressure on capacity in some of the teams was serving to hinder these positive working relationships, and that some people who use services discharge was being delayed as a consequence of this. The trust risk register identified capacity issues within the community teams and monitored action plans, and also monitored delayed discharges in its governance groups ,

Complaints

We saw evidence of regular meetings with people who use services and staff, and also of issues that people who use services had raised being picked up by staff and either resolving, or explaining why a desired outcome was not feasible. Staff were able to explain the complaints process and were informed of the outcome to assist learning for improvement. The number of complaints across adult mental health inpatient services was low, the trust complaints log for a 12 month period showed nine complaints in total, three of which were not upheld and two were still being investigated.

Westlands

Planning and delivery

We found that community teams worked usually closely with the ward and attended planning meetings but that pressure on capacity in some of the teams was serving to hinder these positive working relationships, and that some people who use services discharge was being delayed as a consequence of this.

Right care at the right time

People who use services were very positive about the care they received on the ward and the attitude and responsiveness of staff. However they were unhappy about the fact that their bedroom doors were routinely locked.

Care Pathway

The manager said that the planned admission period was normally about six weeks. Discharge planning was started on admission and discussed in clinical meetings. We saw evidence that people who use services were encouraged to consider the benefits of establishing advanced directives and were supported to do this.

Learning from concerns and Complaints

We saw evidence of a daily focus group meeting with people who use services and staff, and also of issues that people who use services had raised being picked up by staff and either resolving, or explaining why a desired outcome was not feasible. Staff were able to explain the complaints process and were informed of the outcome to assist learning for improvement.

Mill View Court

Planning and delivery

We found that community teams worked closely with the ward and attended planning meetings. A daily professionals meeting took place on the ward to ensure that assessments were proceeding in a timely manner.

Right care at the right time

All people who use services had their own individual bedrooms with en-suite facilities and these were reasonably furnished and decorated.

Are services responsive to people's needs?

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

The ward catered for both men and women with male and female rooms with separate facilities such as toilets and lounges. All bedroom doors are locked with people who use services unable to access them without staff assistance.

We saw evidence that people who use services were encouraged to consider the benefits of establishing advanced directives and were supported to do this.

Although some leisure and social activities were made available to people who use services such as playing pool, puzzles, TV, cooking group, relaxation some said that it was boring on the ward and there was not enough to do. There were less therapeutic activities and few psychology sessions. We were told that the activities coordinator was off sick and that the occupational therapist only worked on the ward on Monday to Wednesdays. People who use services stated that "more activities would make you feel less like you were in prison". People were asked if they would like to have one to one sessions with their primary nurse. On the day of our visit we observed that two people had gone out on leave.

People who use services told us they felt like they were in prison surrounded by walls, fences and locked doors, but that they had managed to go out for walks accompanied by staff.

We saw evidence of a daily focus group meeting with people who use services and staff, and also of issues that people who use services had raised being picked up by staff and either resolving, or explaining why a desired outcome wasn't feasible.

Feedback from people who use services was positive; with people who use services stating that "staff are caring and know who to approach me" that staff speak to their family on their behalf and involve them in planning for future care and discharge. A people who use services who expressed that they had felt vulnerable on the ward were able to discuss their feelings and concerns with the staff and that they "all listen to you".

People who use services stated that the "food is brilliant" and "overfilling" but that sometimes "you don't always get what you have ordered". Staff acknowledged that this occasionally occurs and that they would monitor this in future.

Mental Health Act

We observed the seclusion area which is off the ward and it adhered to the Mental Health Act Code of Practice. The seclusion records were audited by the nurse consultant. Seclusion was monitored and discussed by the trust Mental Health Act Committee.

Care Pathway

We found that community teams worked usually closely with the ward and attended planning meetings but that pressure on capacity in some of the teams was serving to hinder these positive working relationships, and that some people who use services discharge was being delayed as a consequence of this. The trust risk register had identified capacity issues within community teams and had an action plan in place. A register of delayed discharges was maintained and reviewed within the governance committee.

Learning from concerns and Complaints

The number of complaints across adult mental health inpatient services was low, the trust complaints log for a 12 month period showed nine complaints in total, three of which were not upheld and two were still being investigated.

Buckrose

Planning and delivery

We found that community teams worked usually closely with the ward and attended planning meetings but that pressure on capacity in some of the teams was serving to hinder these positive working relationships. Some people's discharge was delayed as a consequence of this. The issue about capacity in the community teams was on the trust risk register and the action plan monitored by the trust board. A daily professionals meeting took place on the ward to ensure that assessments were proceeding in a timely manner. We observed a Community Nurse Practitioner visiting a service user and were told that this happened on a weekly basis.

Right care at the right time

All people who use services had their own individual bedrooms and these were reasonably furnished and decorated.

The ward catered for both men and women with male and female rooms with separate facilities such as toilets and lounges. We saw evidence that people who use services were encouraged to consider the benefits of establishing

Are services responsive to people's needs?

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

advanced directives and were supported to do this. Although some activities were made available to people who use services such as swimming or going out on trips for coffee or shopping, some said that it was boring on the ward and there was not enough to do.

We saw evidence of a daily focus group meeting with people who use services and staff, and also of issues that people who use services had raised being picked up by staff and either resolving, or explaining why a desired outcome wasn't feasible.

Feedback from people who use services was positive, with one person stating that "staff are caring and always have time to listen to you" and are "friendly". People who use services told us they felt "safe on the ward" and that there was "no bullying between people who use services".

We saw that this practice was explained in the welcome pack given to each person on admission. Informal people who use services told us they had their rights read to them on a regular basis, and this was evidenced in the person's records. We also found that an informal service user had left the ward and that this was managed as though the service user was absent without leave for example leave forms were in place similar to s17 leave forms for detained people. This was highlighted as restrictive practice for informal people using services. The trust was responsive by informing the clinical teams and ceased the practice.

The ward exit door has a coded lock for entry and exit. People had to request access and egress through staff. Staff said that they explain this to everyone on admission and repeat this as required.

Care Pathway

There has been a phased planned closure for Buckrose ward which is due for completion in autumn.

Learning from concerns and Complaints

The number of recorded complaints across adult mental health inpatient services was low, the trust complaints log for a 12 month period showed nine complaints in total, three of which were not upheld and two were still being investigated.

Are services well-led?

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.

Summary of findings

Staff told us that they knew who the executive team were within the trust although some staff told us they saw little of them with most communication via email. We saw good examples of ward based leadership.

Staff had positive relationships with the ward managers and with the modern matrons and received regular supervision and an annual appraisal of their personal development needs. There was good multi-disciplinary working.

Our findings

Miranda House Avondale ward

Vision and Strategy

Staff told us they received lots of information by e mail and bulletins relating to the trust vision and values and understood this. Many of the staff had worked at the trust for a long time and were committed to the trust.

Governance

Staff told us that that whilst they knew who the executive leadership were within the trust, they saw little of them and there were some concerns expressed about the significant changes that had occurred at Board level.

Leadership culture

We found that ward managers and other senior staff were very visible and accessible to staff. Staff indicated that the leadership of the ward and above was much improved over recent years. It was clear that staff had a positive relationship with the ward manager and with the modern matron who oversaw the ward.

Staff spoke very positively about their employment, and of their management within the trust. Many staff had worked for the trust for lengthy periods and were committed to the organisation. We found that staff were, in the main, clear about their purpose and function and able to tolerate the pressures faced, through mutual support and a commitment to the care of people who use services.

Engagement

Staff told us that much of the communication from senior managers within the trust was by E-Mail although bulletins were also made available to them from time to time.

Staff confirmed that supervision so that staff had an opportunity to sit with line managers and discuss their performance and development needs, was taken seriously within the trust and occurred approximately monthly. Annual performance development reviews were also carried out routinely and staff indicated that they felt their individual development needs were addressed through these processes. Staff locally felt engaged with the service and were proud of the care they were giving.

Performance improvement

The ward manager indicated that she would sift through the information arriving on the ward, and ensure that important messages were relayed to staff through team meetings and individual supervision. Performance development reviews for staff was working well, staff development needs were seriously addressed and professional development is supported by the management.

People using services are able to use the Meridian survey to give immediate feedback on their care which is done in kiosks around the trust or on a tablet device. This means wards obtain immediate feedback about the care given and to consider how to be responsive to people's needs.

Newbridges

Vision and Strategy

Staff received information by e mail and bulletin relating to the trust vision and values and understood this.

Governance

Staff told us that that whilst they knew who the executive leadership were within the trust. There was a general understanding of the governance systems in place.

Leadership culture

We found that ward managers and other senior staff were very visible and accessible to staff. Staff indicated that the leadership of the ward and above was much improved over recent years. It was clear that staff had a positive relationship with the ward manager and with the modern matron who oversaw the ward

Engagement

Generally people felt that they were listened to by staff. There were ward meetings held in the ward between staff and patients to discuss issues. Staff felt engaged locally by managers.

Are services well-led?

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.

Performance improvement

Staff told us that whilst they knew who the executive leadership were within the trust, they saw little of them and there were some concerns expressed about the significant changes occurring at Board level.

Staff said that much of the communication from senior managers within the trust was by e-mail although bulletins were also made available to them from time to time. The ward manager indicated that she would sift through the information arriving on the ward, and ensure that important messages were relayed to staff through team meetings and individual supervision. Staff confirmed that supervision was taken seriously within the trust and occurred approximately monthly. Annual PDRs were also carried out routinely and staff indicated that they felt their individual development needs were addressed through these processes.

Westlands

Vision and Strategy

Staff received information by e mail and bulletin relating to the trust vision and values and understood this.

Governance

Staff told us that whilst they knew who the executive leadership were within the trust, they saw little of them and there were some concerns expressed about the significant changes occurring at Board level.

Leadership culture

Staff spoke very positively about their employment, and of their management within the trust. Many staff had worked for the trust for lengthy periods and were committed to the organisation.

We found that staff were, in the main, clear about their purpose and function and able to tolerate the pressures faced, through mutual support and a commitment to the care of people who use services.

The charge nurse on duty had been on the ward for almost two years. We found that ward managers and other senior staff were very visible and accessible to staff. Staff indicated that the leadership of the ward and above was much improved over recent years. It was clear that staff had a positive relationship with the ward manager and with the modern matron who oversaw the ward. The ward staff had won a trust award for 'team of the year' for improving people's dignity and respect.

Staff told us that much of the communication from senior managers within the trust was by E-Mail although bulletins were also made available to them from time to time. The ward manager indicated that she would sift through the information arriving on the ward, and ensure that important messages were relayed to staff through team meetings and individual supervision.

Engagement

Staff we spoke with understood the tasks they faced in the ward, but almost all told us they felt they were in a good team and that they felt they were delivering good care and were supported by their managers.

Performance improvement

Staff confirmed that supervision so that staff had an opportunity to sit with line managers and discuss their performance and development needs, was taken seriously within the trust and occurred approximately monthly. Annual performance development reviews were also carried out routinely and staff indicated that they felt their individual development needs were addressed through these processes.

Mill View Court

Vision

Staff received information by e mail and bulletin relating to the trust vision and values and said they understood this.

Governance

Staff told us that that whilst they knew who the executive leadership were within the trust and understood the general governance systems.

Leadership culture

The ward has an acting manager, who has been in post for some time. We found that acting ward manager and other senior staff were very visible and accessible to staff. It was clear that staff had a positive relationship with the acting ward manager and with the modern matron and the nurse consultant who oversaw the ward. We observed a professional multi-disciplinary working model in operation through the recovery star model, which was embedded in practice.

Engagement

Staff we spoke with understood the tasks they faced in the ward, but almost all told us they felt they were in a good team and that they felt they were delivering good care.

Are services well-led?

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.

Performance improvement

Staff indicated that much of the communication from senior managers within the trust was by E-Mail although bulletins were also made available to them from time to time. The acting ward manager indicated that he would sift through the information arriving on the ward, and ensure that important messages were relayed to staff through team meetings and individual supervision. Staff confirmed that supervision was taken seriously within the trust and occurred approximately monthly. Annual performance developments reviews were also carried out routinely and staff indicated that they felt their individual development needs were addressed through these processes. Staff indicated that they felt they would be able to raise concerns if necessary.

Buckrose

Vision

Staff received information by e mail and bulletin relating to the trust vision and values and understood this.

Governance

Staff told us that members of the trust board, including the Chief Executive, visited the ward on a regular basis. Staff perceived this to be in relation to the sensitivities about the imminent closure of the ward.

They said that much of the communication from senior managers within the trust was by E-Mail although bulletins were also made available to them from time to time.

Staff spoke very positively about their employment, and of their management within the trust.

Some staff were concerned about the planned closure of Buckrose ward and the impact of this on the local community. We found that staff were, in the main, clear about their purpose and current and future function and able to tolerate the pressures faced, through mutual support and a commitment to the care of people who use services.

Leadership culture

The ward had a new acting manager, who transferred from another assessment ward within the trust in March 2014. We found that ward manager and other senior staff were very visible and accessible to staff. Staff indicated that the leadership of the ward and above was much improved over recent months. It was clear that staff had a positive relationship with the ward manager and with the modern matron and the nurse consultant who oversaw the ward.

The ward manager told us that he would sift through the information arriving on the ward, and ensure that important messages were relayed to staff through team meetings and individual supervision.

Engagement

The views of staff were collected through supervision sessions. Team meetings were held to discuss a range of governance issues and where concerns could be discussed.

Performance improvement

Staff confirmed that supervision was taken seriously within the trust and occurred approximately monthly. Annual performance development reviews were also carried out routinely and staff indicated that they felt their individual development needs were addressed through these processes. Staff indicated that they felt they would be able to raise concerns.