Central and North West London NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

This was an unannounced focused inspection of the two acute wards for adults of working age at the Campbell Centre, Milton Keynes. We carried out this inspection to follow up concerns raised following a serious incident in December 2022 when a patient died on Willow ward as a result of tying a ligature around their neck. This inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of patient risk on Willow ward. This inspection examined those risks.

This inspection has not been rated. This is because we only inspected two wards out of 17 acute or intensive care wards run by Central and North-West London NHS Trust. Hence, the findings from these two wards do not necessarily reflect the overall quality of acute and intensive care services provided by the trust.

Our last inspection of these wards was in November 2020. Following that inspection, we told the trust it must ensure that patients on Willow ward are protected from risks associated with inconsistent staffing and ensure that appropriate measures are in place to mitigate risks. During this inspection, we found that the trust had made some but not all of the required improvements.

We visited 2 wards during this inspection, both located at the Campbell Centre, Milton Keynes. Willow ward is an acute admission ward for up to 19 female patients. This is where the serious incident occurred. Hazel ward is an acute admission ward for up to 17 male patients.

The service is registered by the CQC to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act1983
- Diagnostic and screening procedures.

Overall summary

We found the following areas the service needed to improve:

- The nature and frequency of incidents on Willow ward indicated that the service was unable to ensure the safety of patients. The service had not addressed the concerns raised at the last inspection about the high number of safety incidents on Willow ward.
- Staff did not carry out observations of high-risk patients on Willow ward in accordance with trust policy. One patient was involved in a ligature incident, despite being assigned to continuous observations. There were some gaps in observation records. Staff were required to carry out continuous observations of patients beyond the maximum period of time set out in the trust's policy. Staff did not always maintain good professional standards whilst carrying out observations.
- Staff did not discuss or sufficiently analyse risk incidents at multidisciplinary team meetings in order to understand the causes and mitigate the risk of such incidents reoccurring.

Our findings

- Staff did not manage the risks associated with prohibited items on Willow ward effectively. Staff did not carry out adequate searches when patients had been found with prohibited items that they had used to harm themselves.
- Although staffing levels were consistent with national guidance, the staff were often not able to provide therapeutic care. Staff were not always able to respond to patients' requests. Leave and activities were sometimes cancelled. Activities that were cancelled were sometimes replaced with an alternative activity.
- Patients did not always have a regular 1:1 session with their named nurse. Staff were not pro-active in carrying out individual discussions with patients to understand their needs and monitor any changes in their level of risk.
- The overall atmosphere on the wards, particularly on Willow ward, was not calm and therapeutic. Wards were often noisy. Wards could often become unsettled. Fights and disputes between patients were not uncommon. Staff were not pro-active in managing conflicts between patients.
- Despite admitting high risk patients, staff on Willow ward did not always update risk assessments after safety incidents.
- Staff and patients told us they did not always feel safe on the wards. Staff did not always respond when emergency alarms were activated.
- Cleaning records were not available on Willow ward.
- The trust did not provide training for staff in conditions presented by high-risk patients.
- The service had high vacancy rates although there was active recruitment taking place..
- Some staff found the electronic patient records difficult to use. It could be difficult for staff who were unfamiliar with the system to access information quickly.
- Incident reports lack sufficient details of the circumstances surrounding the incident. The system for incident classification was not always able to reflect the seriousness of the matter.
- Willow ward had not embedded some of the recommendations made in reports of investigations into serious incidents.
- Handover meetings on Willow ward did not have robust discussions about risks or how to manage them, or provide a clear handover of tasks to manage patients' risks.
- Not all staff had completed and were up to date with emergency life support training although this was planned.
- Staff were not having discussions with patients about their medicines and their potential side effects.
- Staff morale on Willow ward was low. Staff struggled to cope with the pressure of their work. Many members of staff had been subjected to assaults from patients. The operational culture viewed this as part of the job. Staff felt the trust was not doing enough to address this.

However, we also found the following areas of good practice:

- Since our last inspection in 2020, the service had reduced the number of bank and agency staff working on the wards from over 50% to 20%.
- The service had introduced specific training on observations for temporary staff.
- The service had introduced monthly emergency scenario training for staff following a serious incident.
- All wards were clean and well equipped. The wards complied with guidance in relation to mixed sex accommodation.

Our findings

- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff made attempts to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.
- Patients told us they enjoyed the activities on the ward.
- Almost all staff had completed safeguarding training and knew how to report safeguarding concerns.

Is the service safe?

Inspected but not rated

Safe and clean care environments

The wards were clean well equipped, well-furnished and well maintained. However, Willow ward was very noisy and did not create a calm, therapeutic environment. Staff said that colleagues did not always respond when alarm was activated.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Staff completed regular checks of the ward environment. Comprehensive fire safety risk assessments were completed for both wards.

The overall atmosphere on the wards did not feel calm and therapeutic. During our inspection, Willow ward was often noisy. There were instances when shouting and swearing could be heard across the ward. Patients said that it was very difficult to get away from all the noise. They said this was particularly a problem at night, as the communal area was next to some patients' bedrooms. Patients said the ward could often become unsettled. Fights and disputes between patients were not uncommon.

At the previous inspection in 2020, 9 patients on Willow ward were required to share 3 dormitories that each had 3 beds. At this inspection, each room was single occupancy.

Staff could observe patients in all parts of the wards. On Willow ward, the service had installed convex mirrors to improve visibility at blind spots. There were no blind spots on Hazel ward.

The ward complied with guidance and there was no mixed sex accommodation. Willow ward admitted only female patients and Hazel ward admitted only male patients.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The service had completed a risk assessment of potential ligature anchor points throughout the ward. Staff updated this risk assessment each year. The most recent update for both wards had been in September 2022. Ligature cutters were kept in the grab bag and in the nurses' office.

Whilst staff had easy access to alarms, and patients had easy access to nurse call systems, staff said that colleagues did not always respond when alarms were activated. All staff and visitors carried personal alarms. However, some staff on Willow ward told us there had been no response from colleagues when they activated their alarm. For example, one member of staff told they had activated their alarm when a fight broke out between two patients. They said that despite

the alarm being activated, other staff had stayed in their offices and did not respond. The trust was aware of this prior to the inspection and had introduced a manager responder role on the 10 April 2023 to ensure attendance of staff to alarms and to investigate complaints made by staff where alarms were not responded to. Patients had access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, well maintained and well furnished. The layout of the ward meant there was limited natural light and some areas appeared quite dark. However, the wards were clean and equipped with good quality furniture.

Staff followed infection control policy, including handwashing. The service had installed hand gel dispensers at the entrance and other locations throughout the ward.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic rooms for Willow and Hazel wards were secured with keys held by qualified staff on the ward. Both clinic rooms were tidy and there was adequate worktop space.

Staff checked, maintained, and cleaned equipment. However, the clinic room cleaning records for Willow ward were not available. This meant that managers could not be assured that comprehensive cleaning had been carried out each day.

Safe staffing

Whilst staffing levels were consistent with national guidance, there were examples of patients not always receiving therapeutic care. Whilst the completion of mandatory training was satisfactory the trust did not provide training, so staff knew how to support the patients with complex needs.

Nursing staff

The service had set safer staffing levels using a nationally recognised tool called the Mental Health Optimal Staffing Tool. This found that the ward often had more staff working than the recommended establishment. The service had also completed a review of the staff skill mix and was carrying out some improvement initiatives to support staff being able to carry out therapeutic activities.

Despite this staff on Willow ward said that they struggled to meet the needs of the patients. For example, patients' one to one sessions with their named nurse were not happening as regularly as they should. Staff said they struggled to give patients the time and support they needed. Patients said they very rarely had any 1-1 discussions with nurses. We reviewed evidence of 1:1's with 2 patients. We found little evidence of registered nurses having 1:1 time with either patient, other than immediately after incidents. There is no evidence of nurses proactively offering the patients 1:1 time. However, one patient said that if they specifically asked for support, a member of staff would speak with them.

On many occasions, patients had their escorted leave or activities cancelled. Staff and patients both said that staff were often unable to respond to patients' requests to leave the ward, requests for medication or requests to see a doctor. In these circumstances, patients could be frustrated, and the situation could escalate, taking up more staff time. Patients said that staff were 'rushed off their feet' and that patients were constantly asking them to do things.

Staff also said that staffing shortages meant they were assigned to enhanced observations of patients for periods of time far longer than recommended in the trust's policy. For example, on Willow ward one member of staff said they had been assigned to the continuous observation of one patient for 5 hours.

Our findings

Staff said that, on some occasions, staffing fell below the recommended staffing levels, usually due to unexpected sickness. They said that it was often difficult to find bank or agency staff to attend the ward at short notice.

The service had high vacancy rates. In April 2023, the vacancy rate for Willow ward was 34% and for Hazel ward 37%. However, the centre had recently recruited 5 nurses and 2 healthcare assistants for Hazel ward. The service had also appointed 2 healthcare assistants, 6 nurses and 2 senior nurses for Willow ward.

The service had reducing rates of bank and agency staff. The service used bank and agency nurses to fill gaps in shifts and this had reduced since the previous inspection. At the previous inspection in November 2020, more than half of all shifts were provided by bank or agency staff. At this inspection, 18% of all shifts were covered by bank staff or substantive staff doing additional shifts. Two percent of shifts were covered by agency staff.

When possible, managers limited their use of bank and agency staff and requested staff familiar with the service. Between November 2022 and April 2023, 47% of bank shifts were filled by substantive staff. The ward managers told us temporary and substantive staff preferred to fill shifts on Hazel ward due to the lower acuity of patients. Managers said that in response to this, they were starting a rotation system so staff would have to work shifts on both wards. Patients told us they felt there was always different staff working there.

Managers had introduced procedures to ensure that all bank and agency staff had an induction and understood the service before starting their shift, although these had always ensured that safe practice took place. Following our inspection in 2020, we told the trust that it must ensure patients on Willow ward are protected from the risks associated with receiving care from an inconsistent staff group. In response, the trust had introduced training on observations for all bank and agency staff. The new arrangements required these staff to sign a form to confirm they understood the procedure. However, despite these arrangements, the trust's initial investigation into the death of a patient in December 2022 on Willow ward found that an agency member of staff had not completed observations in accordance with the policy in the hour leading up to the patient's death.

Staff did not share key information to keep patients safe when handing over their care to others. We found that handover meetings were unstructured and did not provide staff with sufficient information about patients' risk. Records showed that multidisciplinary team meetings did not included discussions about all risk incidents.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The service had enough medical staff. There were 2 ward doctors and a specialist doctor in post. Out of hours medical cover was available through an on-call duty doctor and consultant psychiatrist. The consultant psychiatrist told us there was adequate cover.

Managers could call locums when they needed additional medical cover. A locum consultant had been in post since January 2023.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. The overall compliance level was 81% on Willow ward and 90% on Hazel ward. However, on Willow ward only 53% of staff required to complete emergency life support (ELS) training had done so. Eight staff had not completed this training. However, the manager explained that 2 members of staff were on long term sick leave and 2 staff members had just returned from long term sick leave. Three staff members were booked for this training in July 2023 and 1 staff member was booked for this training in August 2023.

Our findings

The mandatory training programme was comprehensive but did not meet all the special needs of patients and staff. For example, Willow ward admitted a high number of patients with emotionally unstable personality disorder (EUPD), yet staff told us they had not received any specific training on this disorder. Similarly, although both wards would regularly admit autistic patients and patients with learning disabilities, there was no specific training on meeting the needs of these patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. All training completed by staff was recorded. This enabled managers to see the training compliance for each staff member on a training dashboard. Managers discussed mandatory training compliance during staff meetings.

Assessing and managing risk to patients and staff

Staff did not always manage risks to patients well. Patient observations were not always undertaken in line with trust policy or at all. Staff did not always discuss risk incidents in multidisciplinary team meetings. Staff did not always update risk assessments after incidents. Whilst there was some evidence of staff de-escalating and managing challenging behaviour, patients gave examples of when staff had failed to intervene in incidents.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, although they did not review this regularly, including after any incident. Risk assessments showed that Willow ward admitted a high number of patients with an emotionally unstable personality disorder (EUPD). EUPD, of a severity that requires admission to hospital, is often characterised by patients engaging in impulsive behaviour that can be very harmful to themselves. This means that these patients present a very high risk. Despite this level of risk, we found that staff did not update risk assessments after incidents. We reviewed 8 patient care records. Staff had not updated risk assessments for 6 of these patients for at least 2 weeks prior to the inspection. For one patient, there were no risk events recorded on their risk assessment, despite there being 6 ligature incidents. For another patient, only 1 out of 5 ligature incidents was recorded as a risk event.

Staff used a recognised risk assessment tool. Staff used that standard risk assessment tool on the electronic patient record.

Management of patient risk

Staff usually knew about any risks for each patient but did not always take effective action to prevent or reduce risks. When patients presented a heightened level of risk, staff increased the frequency of observation. When a patient presented a significant level of risk, a member of staff was assigned to be with them all the time. However, the quality of carrying out and recording observations was poor. For example, we found a significant number of gaps in recording these observations. There was one example of a patient on Willow ward being involved in a ligature incident, despite being assigned to continuous observations. Staff and patients said that bank staff listened to music on headphones whilst carrying out observations. One patient said that night staff observing her would bring pillows and blankets into her room to make themselves comfortable. Following this occurrence, which preceded the inspection, a disciplinary process was undertaken by the trust. An initial investigation by the trust into the death of a patient on Willow ward in December 2022 found that staff had not carried out high-level intermittent observations and that they had falsified records to indicate that they had.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. Staff did not always discuss risk incidents in multidisciplinary team meetings. For example, the care record for one patient on Willow ward showed that ligature incidents took place on 13, 15 and 20 April 2023. However, there was no mention of these incidents at this

patient's ward round on 21 April 2023. For another patient on Willow ward there was a brief mention of ligature incidents at the multidisciplinary team meeting but no analysis of why they happened, or steps taken to prevent further incidents. Furthermore, there was no evidence of nurses proactively offering patients 1:1 time with patients in order to identify any changes in risk. We saw little interaction between staff and patients in the communal area, particularly in Willow ward.

Staff could observe patients in all areas, however, on Willow ward there was often no staff in communal areas to carry out observations.

Staff understood trust policies and procedures about searching patients or their bedrooms to keep them safe from harm, but they were not proactive in carrying out searches to address risks they had identified. For example, records showed that one patient on Willow ward had swallowed a battery from their vape, shortly after their admission to the ward. There was no evidence to show that staff had searched for other items in the patient's room that they could use to harm themselves, nor that there was discussion about risk management between staff and the patient. Similarly, at the meeting on 26 April 2023 staff on Willow ward discussed concerns that a patient had a razor to self-harm. The staff present were unaware if the razor had been removed from the patient. There continued to be a number of incidents on Willow ward that involved patients harming themselves with prohibited items.

Use of restrictive interventions

Levels of restrictive interventions were low. The service used physical interventions. Ward managers told us the levels of restrictive interventions for these wards were low. In the 2 months prior to inspection there had been 14 incidents of restraint on Willow ward, and 15 on Hazel ward.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff attempted to support patients and de-escalate situations before using restraint. Staff felt there was always enough staff to carry out restrictive interventions. They said they would not attempt to restrain a patient unless there were sufficient staff present.

Staff followed NICE guidance when using rapid tranquilisation. In March 2023, there were 2 instances of staff using rapid tranquilisation on Willow ward and 3 on Hazel ward. Records showed that staff had completed the required physical health observations after the rapid tranquilisation in order to ensure there were no negative side effects for the patient.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. On Willow ward, 90% had completed safeguarding adults level 3 training and 95% had completed safeguarding children level 3. On Hazel ward, 96% of staff had completed safeguarding adults level 3 training. All staff on Hazel ward had completed safeguarding children level 3 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, there had been 2 transgender patients admitted to the wards over the previous year. Staff worked hard to ensure that all staff understood the patients preferred pronouns and used them correctly.

Our findings

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns. Patient care and treatment records showed evidence of appropriate safeguarding referrals being made.

Staff followed clear procedures to keep children visiting the ward safe. Patients could meet with children in a designated area away from the ward.

Staff access to essential information

Staff had access to clinical information and maintained high quality clinical records. However, if was not always easy to find information quickly.

Patient notes were comprehensive and all staff could access them. Most information about a patient's care and treatment was stored on an electronic patient record. Paper forms were used to record enhanced observations. These forms were uploaded onto the electronic system. However, staff told us the electronic record system was difficult to use. Information was fragmented between the different types of recording systems. Risk incidents were mostly recorded in the patient's progress notes. The handover spreadsheet was not uploaded onto the system. There was a risk that finding patient risk information could be difficult for temporary staff.

Records were stored securely. Records could only be accessed by staff entering a username and confidential password.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. All information relating to the prescribing and administration of medicines was recorded on the patients' medicine administration records.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We reviewed 6 patient care records, 5 medicine administration records and the medicine administration records audits from January to March 2023. Staff reviewed medicines and their effects. However, in 4 patient care records there was no evidence side effects of their medicines had been discussed with patients, and in 2 patient care records there was no evidence the patient was involved in discussions around medication and treatment.

Staff completed most medicines records accurately and kept them up-to-date. However, on the 5 records we reviewed, we found 2 occasions medication was not given to a patient. This was recorded as patient not available, although no reason for this was given.

Staff stored and managed all medicines and prescribing documents safely. Access to medicine storage areas and cupboards was appropriately restricted to designated staff. The service used thermometers to monitor fridge and ambient room temperatures. We reviewed the daily fridge temperatures for the previous 3 months and found no gaps. The service stored controlled drugs appropriately.

Staff learned from safety alerts and incidents to improve practice. Medicines errors and incidents were reported using an electronic system. The daily safety huddle included a discussion on medicine incidents and concerns.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. No patients were receiving medicine above the limits set out in the British National Formulary.

Our findings

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Any medicines or treatment regimes that required additional monitoring would have these carried out within the required timeframe.

Track record on safety

The service did not have a good track record on safety.

Following our last inspection, in November 2020, we told the trust that it needed to do more to manage and mitigate risks to patients. In that report, we raised concerns about the high number of safety incidents on Willow ward.

At this inspection, we found that there had been no improvement. On Willow ward the number of self-harm incidents had increased from 123 in the six months before the 2020 inspection, to 138 between November 2022 and April 2023. The number of incidents involving violence and aggression had increased from 18 in the six months before the 2020 inspection, to 53 between November 2022 and April 2023.

In addition, in December 2022, a patient died on Willow ward after tying a ligature around their neck. The trust's initial investigation into the patient's death found that an agency member of staff had failed to carry out the required high level, intermittent observations of the patient during the hour before their death, and that staff had falsified the observation to indicate they had done these observations. The investigation also found there had been delays in the delivery of emergency life support equipment, a failure to follow up actions from the multidisciplinary team meeting, and a failure to record interactions with the patient. The investigation into the patient's death was ongoing and had not been completed at the time of inspection. In the four months since that patient's death, there had been a further 48 ligature incidents on the ward.

On Hazel ward, between November 2022 and April 2023, there had been 9 incidents involving self-harm and 39 incidents involving violence and aggression.

Reporting incidents and learning from when things go wrong

Learning from incidents was not always embedded and this did not always result in improvements to the service. Initial records of incidents did not always contain sufficient detail. However, staff recognised incidents and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff told us they were encouraged to report all incidents and near misses using an electronic incident reporting system in line with trust policy.

Staff raised concerns and reported incidents and near misses although records tended to lack details and the classification of impact did not always reflect the seriousness of the incident. We reviewed 19 incident reports on Willow ward involving ligatures from March and April 2023. These reports contained few details about the circumstances of the incidents. Most incidents were classified as 'no harm'. Two incidents in April 2023 were classified as 'low/minimal harm'. This meant that the overall impact rating for all these incidents would be low and therefore they may not be escalated to senior managers for oversight. The trust had a system of daily review of all incidents by the quality governance team to ensure all incidents were managed appropriately.

Managers debriefed and supported staff after any serious incident. Staff we spoke to told us they had opportunities to debrief and had some support from management following incidents. They said that, occasionally, a psychologist would facilitate a discussion about how to work with challenging behaviour.

Our findings

Managers investigated serious incidents thoroughly. When serious incidents occurred, managers conducted an initial management review within 72 hours of the incident.

Staff met to discuss the feedback and look at improvements to patient care. We reviewed ward team meeting minutes from both wards and clinical oversight group meeting minutes for the previous 6 months, and operational management meeting minutes for the previous 3 months. These showed management and staff discussed learning from incidents. However, there was no evidence of specific discussions around managing the risks of patients with emotionally unstable personality disorders in these meetings. The trust held a regular meeting attended by members of the multidisciplinary team and multiple agencies to discuss the needs of these patients.

There was evidence that some changes had been made as a result of investigations into incidents and others still needed to embed. The initial report into the death of a patient on Willow ward in December 2022 made recommendations for immediate action. This included the nurse in charge of each shift checking whether all temporary staff were fully inducted at the start of the shift, introducing protected time in ward rounds to ensure risks identified could be communicated to the ward staff, conducting an audit of ward round actions, introducing additional multidisciplinary team handovers at 2pm each day and introducing monthly emergency simulation training. From January 2023, simulation training had been taking place each month.

However, the additional handover meetings on Willow ward were poorly attended. The meetings did not have a clear format, there was no specific focus on risk and actions to manage this during the next shift, and there was no clear allocation of tasks in relation to patient issues. The audit of ward round actions had not been completed.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had an understanding of the services they managed. However, staff told us senior managers were not always visible on the wards

The ward manager for Willow ward had been in post since January 2021. On Hazel ward, the ward manager had been in post as an interim ward manager since January 2023. Both ward managers had worked in the trust at the Campbell Centre most of their careers. The consultant was a locum and had been in post since January 2023.

Staff said the ward managers were supportive and that they were doing their best in difficult circumstances. They said the ward managers and matrons were helpful, and they spent time with patients. However, staff said the leadership of the hospital could be better. Staff said there were a lot of managers at the hospital, and it was hard to work out what these people did. They said they did not have much contact with senior managers. They said senior managers were rarely present on the ward.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff told us that they wanted to provide the best possible care to the patients. Some patients told us that staff were respectful and supportive of them and have helped them progress and improve within the service. Permanent staff knew the patients and their risks well.

Our findings

Culture

Staff morale was low. The felt they were under considerable pressure and that this pressure had a negative impact on patient care. Many staff had been assaulted by patients. Staff felt the trust did not do enough to prevent this. However, some staff felt supported by their colleagues. Staff felt able to speak up about concerns. There was a leadership development programme in place for senior nurses.

Staff on Willow ward said that morale within their team was low. Staff said that they and their colleagues could not cope with the pressure of their work. They said the quality of care provided was often compromised by the pressure they were under. Staff on Willow ward said they were frequently subjected to assaults. A healthcare assistant said they had been pushed by a patient. A nurse said they had been kicked in the ribs by a patient the previous day. They said another nurse had been taken to the emergency department of the neighbouring hospital. They both said they felt it was part of their role to accept this. One healthcare assistant described some shifts as being horrific.

Both male and female staff said they had difficulties on the ward. Male staff on said they were restricted in some elements of nursing care they could provide to female patients. Female staff said they were always assigned to enhanced observation of female patients, sometimes for very long periods of time. Some staff received abuse from patients and felt the trust did not do enough to prevent this from reoccurring.

However, some staff said that people in their team got on well and they enjoyed working with their colleagues. They said their immediate colleagues were supportive and co-operative. Some staff said they were proud of the work they did. Staff said they prided themselves on keeping patients safe and, despite many challenges, they came back to work because they were committed to patients.

Staff said they felt able to speak up about any concerns they had about the care provided to people. They said that if there was a problem, they would report it. The freedom to speak up guardian (FTSUG) last visited the centre in February 2023

The centre had programmes in place to develop staff. The centre had a leadership development programme for senior nurses. The ward manager for Willow ward attended in 2022 to develop their leadership skills.

Governance

Our findings from the other key questions demonstrated that not all governance processes operated effectively at team level and that performance and risk were not always managed well.

The centre had failed to take sufficient action to address the high number of incidents on Willow ward. The nature and frequency of incidents indicated that the service was unable to ensure the safety of patients.

The centre utilised a number of meetings to manage patient risk and share information. There was a daily safety huddle where patients, incidents and staffing was discussed. This was followed by the multidisciplinary team (MDT) hand over where management plans were put in place. The centre had implemented both individual and joint ward meetings following this suggestion from the freedom to speak up guardian. However, these meetings had failed to improve underlying problems such as a high level of incidents and a reluctance by some staff to pro-actively engage with patients on Willow ward.

Following a patient's death on Willow ward in December 2022, the centre had introduced an additional MDT handover in the afternoon. However, we observed that these were not effective. These meetings on Willow ward were not attended by the MDT, there was no focus on actions to manage patient risk or clear allocation of tasks.

Our findings

The centre held monthly local care quality and innovation forum (CQUIF) meetings. These were attended by managerial staff, including the service manager, matrons, ward managers and leads for professional groups. These meetings facilitated the sharing of information and learnings amongst the trust's mental health services. They focused on quality governance including incidents, serious incidents, audits, innovation, risk registers and patient feedback. However, there appeared to be poor communication in sharing the contents of these meetings with staff on the wards.

The centre also held monthly Milton Keynes mental health clinical oversight group meetings. These meetings were to review learning following incidents, serious incidents and internal/external reviews. Meeting minutes showed these discussions were taking place.

The centre had audits in place. We reviewed the patient care record audits from January to March 2023. From the audits we reviewed, these audits identified problems in recording of risk events and engagement between staff and patients on Willow ward. However, these audits had not led to sufficient improvements.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

There was a risk register in place for Campbell Centre. The main risks for the service were staffing and managing the risks of the complex patients on Willow ward. Some staff said they had raised concerns with managers about staffing levels many times, and staff told us they did not feel the staffing level and skill mix was adequate for the ward.

The centre had a high vacancy rate. The service had recently recruited a number of nurses and healthcare assistants to fill these vacancies. The ward managers said temporary and substantive staff preferred to fill shifts on Hazel ward due to the lower acuity of patients. They were starting a rotation system so staff would have to work shifts on both wards.

Both wards had a ward manager during the day, a clinical site co-ordinator at nights, and a weekend and bank holiday clinical site co-ordinator.

Information management

Patient care and treatment information was recorded in electronic and paper records. Most patient care information was kept electronically. Continuous observations were recorded electronically. However, high level intermittent observations were recorded on paper. Within the electronic system all patient risk information was kept in patient progress notes despite there being a dedicated section for risk.

The ward managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Incidents and safeguarding concerns were reported and investigated, and learning was shared.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers engaged with partner organisations.

Our findings

Learning, continuous improvement and innovation

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The centre had not made significant improvement since the last inspection in November 2020. The acuity of patients, and the number and types of incidents remained high, particularly on Willow ward. Following the last inspection, the trust implemented weekly multi-disciplinary complex care meetings to focus on the needs of patients with very complex presentations such as emotionally unstable personality disorders (EUPD). The meetings around patient risks we did observe were not well attended, and they did not have robust discussions or handover of all patient risks.

The staff were not aware of any specific quality improvement projects.

Our findings

Outstanding practice

There were no areas of outstanding practice.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Actions the trust must do:

- The trust must work to reduce the number and frequency of safety incidents on Willow ward (Reg. (12(1)))
- The trust must ensure that observations of patients on Willow ward are carried out in accordance with the trust's policy and that observations are comprehensively recorded. (Reg. 12(2)(b))
- The trust must ensure that staff fully embed any learning from incidents (Reg 17(2)(a)(b))
- The trust must ensure that staff manage the risks associated with prohibited items on Willow ward appropriately. (Reg. 12(2)(b))
- The trust must ensure there are sufficient numbers of suitably qualified staff to ensure patients' needs are met including leave and 1:1's. (Reg 18(1))
- The trust must ensure that staff update risk assessments after patient safety incidents. (Reg 12(2)(a))
- The trust must ensure that training be provided to help staff meet the needs of all patients, for example patients with emotionally unstable personality disorder. (Reg 12(2)(c))
- The trust must ensure that handover meetings on Willow ward are effective, and that staff are aware of patients' risk at the start of each shift. (Reg. (12(1)))
- The trust must ensure that staff have completed training on emergency life support. ((Reg 12(2)(c))

Actions the trust should do:

- The trust should ensure that staff take a pro-active approach in providing individual time with patients to understand their needs and assess any changes in risk.
- The trust should ensure that each ward provides a safe, calm and therapeutic environment.
- The trust should ensure that all staff are aware of the protocol on how to respond when emergency alarms are activated.
- The trust should continue the work to address high vacancy rates.
- The trust should ensure that the impact rating on incident records accurately reflects the severity of the incident.
- The service should ensure that staff discuss and record the effects of medicines and their side effects with patients.
- The service should ensure that it addresses poor morale on Willow ward.

Our inspection team

The inspection team consisted of a lead inspector, another inspector, and 2 specialist advisors.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with 5 patients who had been using the service.

Patients said they did not feel safe on Willow ward. They said that staff were rushed off their feet. They said the ward could be very noisy, both during the day and at night. One patient described how, on the day before the inspection, two patients had been involved in a fight with each other which involved shouting and screaming. Two other patients said they had been assaulted. Patients felt that staff were reluctant to intervene in such incidents. Most patients said they had not had individual time with nurses and that there were never any staff around for them to talk to.

One patient said they were autistic. They said that staff didn't understand their condition and often responded in an inappropriate manner. This patient said that staff had failed to create appropriate boundaries to keep her safe.

However, patients said that some of the staff were very nice. Patients said they enjoyed activities on the ward, such as African drumming and cooking. They also said the gym was very good and that the gym instructor was supportive. One patient was actively involved in voluntary work for the trust. They were involved in interview panels and was invited to talk at a recent staff conference.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing