Good

Cambridgeshire and Peterborough NHS Foundation Trust

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

Quality Report

Elizabeth House
Fulbourn Hospital
Fulbourn
Cambridge
CB21 5EF
Tel: 01223 726789
Website: www.cpft.nhs.uk

Date of inspection visit: 18 - 22 May 2015
Date of publication: 13/10/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT113	CPFT at Fulbourn Hospital	Mulberry 1 ward Mulberry 2 ward Springbank ward	CB21 5EF
RT1JJ	CPFT at Cavell Centre	Oak 1 ward Oak 2 ward Oak 3 ward	PE3 9GZ
RT1JJ	CPFT at Cavell Centre	Poplar ward (PICU)	PE3 9GZ

Summary of findings

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

Summary of findings

Ratings

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

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated this core service as 'good' because:

- We received positive feedback from patients about the care they received and found that staff across the service were committed to providing good quality care to the patients.
- We found positive multidisciplinary work and observed that staff were caring, compassionate and supported patients.
- Patients received regular one to one time with staff
- The bed management system was effective, ensuring that patients receive timely access to services when they required it.
- The leadership was visible and proactive on all of the wards.

However:

- Staff had assessed ligature points on all wards. However, the low level of staff at night on Poplar ward meant that patients could potentially access ligature points without the notice of staff.
- The clinical rooms for Oak 1, Oak 2 and Oak 3 wards were not fit for purpose and did not comply with infection control guidance.
- The nursing and medical staffing levels on Springbank ward were poor.
- There were a number of concerns relating to Mental Health Act 1983, specifically consent to treatment (Section 58) and practice which amounted to seclusion.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff had assessed ligature points on all wards. However, the low level of staff at night on Poplar ward meant that patients could potentially access ligature points without the notice of staff.
- The clinical rooms for Oak 1, Oak 2 and Oak 3 wards were not fit for purpose and did not comply with infection control guidance.
- The nursing levels, on Springbank ward, were poor.
- Prone restraint was used on occasion.

However:

- Risk assessments were thorough and comprehensive, reflecting the needs and risks of patients.

Are services effective?

Good

We rated effective as good because:

- Admission assessment processes and care plans, including for physical healthcare, were good.
- Patients received regular one to one time with staff
- Multi disciplinary meetings were effective in planning and evaluating care for patients

However:

- There were a number of concerns relating to Mental Health Act 1983, specifically consent to treatment.

Are services caring?

Good

We rated caring as good because:

- We received positive feedback from patients about the care they received.
- There were a range of activities taking place for patients to participate in.
- We observed kind, caring interactions between staff and patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The environments were conducive for mental health care and recovery.

Summary of findings

- Information about how to complain was available for patients and staff had a good knowledge of the complaints process.
- The bed management system was effective, ensuring that patients receive timely access to services when they required it.

Are services well-led?

Good

We rated well-led as good because:

- The leadership was visible and proactive on all of the wards.
- There was good evidence of learning from incident and complaints.

However:

- Governance systems on Springbank ward were not as robust as the other wards inspected.

Summary of findings

Information about the service

The acute wards for adults of working age are based at the Fulbourn Hospital in Cambridge, and the Cavell Centre in Peterborough. The trust operated a '3-3-3' pathway model of assessment, treatment and recovery. The model consists of three stages of care, namely three days of assessment, three weeks of treatment and three months of recovery. Each ward had a designated function, providing services for adults aged 18 years old and over.

The trust also provides a psychiatric intensive care unit (PICU) for adults aged 18 years old and over. This is based at the Cavell Centre in Peterborough.

Cambridgeshire and Peterborough NHS Foundation Trust had been inspected 12 times since registration with the CQC. Of these, ten inspections looked at the acute wards for adults of working age and psychiatric intensive care unit.

At the time of this inspection, there was one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, from September 2013, at the Fulbourn Hospital. This was in relation to safeguarding people who use services from abuse. During this inspection we reviewed this area of previous breach.

Our inspection team

Our inspection team was led by:

Chair: Professor Steve Trenchard, Chief Executive, Derbyshire Healthcare NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Lyn Critchley, mental health hospitals, CQC

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about Cambridgeshire and Peterborough NHS Foundation Trust and asked other organisations to share what they knew. We carried out an announced visit from 18 to 22 May 2015.

During the inspection visit, the inspection team:

Summary of findings

- Visited all seven wards and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 28 patients who were using the service and collected feedback from one patient using comment cards.
- Spoke with each ward manager.
- Spoke with 40 other staff members, including doctors, nurses and occupational therapists.
- Spoke with two senior matrons with responsibility for these services.
- Attended and observed two staff shift hand-over meetings and two multi-disciplinary team meetings.
- Looked at the medication charts of 35 patients.
- Carried out a specific check of the medication management on Springbank ward.
- Looked at 30 patients' care records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients we spoke with were mostly positive about the staff, and their experience of care on the wards. All but one of the patients we spoke with felt they were treated with respect and dignity by the staff. Patients and their families or carers had the opportunity to be involved in discussions about their care.

Patients were admitted to hospital in a timely manner. We were told that there were generally enough staff on duty on each of the wards, and activities or leave from the ward had not been cancelled as a result of a shortage of staff.

There was information about the trust available for patients using the service. Patients could access the advocacy and the patient advice and liaison service (PALS) to get information and give feedback about the trust's services. Each patient we spoke with confirmed that they knew how to make a complaint.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should review systems relating to the monitoring of the administration of, and adherence with, the Mental Health Act 1983, and associated Code of Practice, specifically in relation to consent to treatment (Section 58) and practices amounting to seclusion.
- The trust should review restraint practices involving the prone position.
- The trust should review the suitability of clinical rooms for Oak 1, Oak 2 and Oak 3 wards.
- The trust should review the medical and nursing staffing situation on Springbank ward.
- The trust should review the night staffing levels on Poplar ward, taking into account the ligature risks on that ward.
- The trust should review the availability of psychological input on Mulberry 1 and Mulberry 2 wards.

Cambridgeshire and Peterborough NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mulberry 1 ward Mulberry 2 ward Springbank ward	CPFT at Fulbourn Hospital
Oak 1 ward Oak 2 ward Oak 3 ward	CPFT at Cavell Centre
Poplar ward (PICU)	CPFT at Cavell Centre

Mental Health Act responsibilities

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

There were systems in place to ensure compliance with the Mental Health Act (MHA). However, adherence to the guiding principles of the MHA Code of Practice were variable. We found a number of times where compliance with the MHA and MHA Code of Practice were poor. These included issues relating to practices amounting to seclusion and consent to treatment (Section 58).

Training records showed us that 87% of staff had received MHA training. This training recurred on a three yearly basis. When we spoke with staff they demonstrated a working knowledge of the MHA.

Detailed findings

There was a clear process for scrutinising and checking the receipt of MHA documentation. We found overall that the MHA record keeping and scrutiny were satisfactory.

Mental Capacity Act and Deprivation of Liberty Safeguards

89% of staff had received training in the Mental Capacity Act 2005 (MCA). This training recurred on a three yearly basis. When we spoke with staff they demonstrated a working knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).

None of the patients receiving care and treatment during our inspection were under a DOLS.

Patients' capacity to consent to their care and treatment was always assessed on their admission or an ongoing basis. However, the quality of these assessments varied from one sentence confirming whether or not a patient had capacity, to a comprehensively documented MCA assessment.

Requires improvement

Are services safe?

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

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

Our findings

Acute Wards

Safe and clean environment

- The ward environments were clean and tidy, in a good state of repair and offered an environment conducive for mental health recovery. The ward layouts allowed staff to observe most parts of the ward. Where this was not possible due to corners, mirrors had been mounted in the corners to aid observation. We saw completed environmental risk assessments on each of the wards. These were regularly updated.
- Springbank, Oak 1 and Oak 2 wards provided single sex accommodation only, whereas Mulberry 1, Mulberry 2 and Oak 3 provided accommodation for both male and female patients, with gender specific day areas. We found that all the wards met the Department of Health's guidance on eliminating mixed sex accommodation.
- The majority of the wards had accommodation comprising of single rooms with ensuite facilities. However, we found some two bedded accommodation on Mulberry 2 ward.
- Each ward had undertaken, and updated when necessary, ligature risk assessments. There were minimal ligature points on the wards. Control measures in place, to minimise the risk to patients, included the use of nursing observations and alterations to furnishings. A ligature risk had recently been identified on anti-ligature furniture. All staff were aware of the risk and arrangements were being made to remove the risk. However, ward managers were unaware of when this work would be undertaken. Staff were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed. Each ward had ligature cutters available and accessible in the event of an emergency occurring.
- Call bells in bedrooms, for patients to use to attract the attention of the staff, were not available on Oak 1, Oak 2 or Oak 3 wards. Two ward managers explained that they were looking at the temporary solution of a portable call bell in bedrooms for when patients may need to summon the assistance of staff. We saw an example of this. Call bells were available in each bathroom and shower room on these wards, and throughout Mulberry 1, Mulberry 2 and Springbank wards.
- There were no seclusion facilities in the wards we inspected. On Mulberry 2 ward, we were informed that there was no seclusion facility. The ward did however have an "intensive nursing area" (INA). This area consisted of a vestibule, two bedrooms (though we were informed that only one bedroom was used at a time) and one toilet/shower room. A senior member of staff explained to us that the INA was used to de-escalate patients who presented with disturbed behaviour. We were told, by a senior member of staff, that patients are "boundaried" in the INA. The door was not locked but staff acted as a barrier to prevent the patient leaving the room, if necessary. If a patient did attempt to leave the room, we were told by a senior member of staff, that the staff would encourage them to return but if this failed the staff would return the patient to the room using physical intervention. Whilst the door of the INA did not lock, this practice as implemented on the ward amounted to seclusion. As such, the bedrooms fell below the specification for a seclusion room as, for example, there were unprotected electrical sockets, hard/sharp edges to radiator grill, ligature risks from door handles, and risk of fashioning weapons from wooden door surrounds.
- Practices were in place to ensure infection control and staff had access to protective personal equipment such as gloves and aprons. All of the wards were clean and tidy and we were told by staff the cleaning services were good. Training records showed us that 95% of staff had received training in infection prevention and control.
- There were fully equipped clinical rooms on Mulberry 1, Mulberry 2 and Springbank wards. However, Oak 1, Oak 2 and Oak 3 wards had a very small clinical room each, where they dispensed medicines. There were no hand washing facilities. We observed, on Oak 2 ward, staff had to leave the room to prepare medicines in the area where patients made their own drinks and snacks. This posed an infection control risk. A ward manager informed us that a business plan had been submitted to the Trust for an improved clinical area.

Requires improvement

Are services safe?

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

- Medicines were stored securely. Records showed that room and fridge temperatures were recorded daily. Temperatures were within the required range. We looked at the medicine administration records for 31 patients. We saw appropriate arrangements were in place for recording the administration of medicines on five of the wards. However, on Springbank ward, we found missed signatures against some prescribed medications. The trust's pharmacist had completed an audit which had identified the missing signatures. However, the ward manager had not been aware and had not initiated any action to rectify the issue. On the remaining wards, the records showed patients were receiving their medicines when they needed them. If patients were allergic to any medicines this was recorded on their medication administration record.
- All the wards had resuscitation equipment bags. Although the bags should be checked on a daily basis, we found on two wards this was not completed on a consistent basis and had not been monitored by the managers. For example, on Oak 1 ward the emergency bag had not been checked for the two days prior to our inspection, though it had been consistently checked prior to this. On Oak 3 ward we found two airways (used to maintain or open a patients' airway when they are unconscious) had expired on 30 April 2015. We drew this to the attention of the ward manager who arranged immediate replacements. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.
- The gardens leading from each ward provided a spacious area for patients to access fresh air. Each garden appeared well maintained and had sufficient garden furniture available. There were covered areas available for patients to use during inclement weather. The access to the gardens was locked at midnight, though patients could request to go for a cigarette after this time, but were accompanied by a member of staff.
- Wards had locks on the main entrances with entry and exit controlled by staff. Signs were prominently displayed on ward doors providing informal patients information about their rights to leave the ward. Staff carried personal alarms. During our inspection, we were offered personal alarms.

Safe staffing

- On five of the six wards we visited, staff told us that there were generally enough staff on duty to meet the needs of the patients. However, on Springbank ward, staff told us that the ward was often short of staff. From the information the trust provided us, relating to Springbank ward, we saw that 3257 hours, for qualified staff, had been requested from temporary staffing department between November 2014 to April 2015. We noted that 36% of the hours had been filled by bank staff, and 41.5% by agency staff. 22% of the requested shifts remained unfilled, which meant that the wards operated short of staff, or the ward manager or matron would undertake the shift. 66.8% of the hours for unqualified staff had been filled by bank staff, and 17% by agency staff. 16% of the requested hours remained unfilled. This information confirmed that the ward was often short of staff. On the day of our inspection we found one permanent qualified nurse working with an agency qualified nurse, and three health care assistants. This met the safe staffing levels.
- When we reviewed the same information for the remaining wards we saw, on average, that each ward had requested 1795 hours for qualified nurses from bank and agency staff between November 2014 to April 2015. We noted, on average, that 58% of the hours had been filled by bank staff, and 32% by agency staff. 10% of the requested shifts remained unfilled, which meant that the wards operated short of staff, or the ward manager or matron would undertake the shift. We also saw that, on average, 3536 hours, for unqualified staff, had been requested. We noted, on average, that 77% of the hours had been filled by bank staff, and 16.5% by agency staff. 7% of the requested hours remained unfilled.
- The ward managers told us that they are able to adjust staffing levels daily to take into account increased clinical needs. This included, for example, increased level of observation or patient escort. Some requested hours were due to staff sickness and existing staff sickness and vacancies. From the information provided by the trust, we saw the average staff vacancy rate, per ward, between April 2014 to March 2015, was 11%. The average staff turn-over rate for the same time period was almost 2%.

Requires improvement

Are services safe?

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

- The Springbank ward manager told us that on approximately two occasions per month escorted leave or ward activities were cancelled because there was a shortage of staff. This was not the case on the other wards we visited.
- Bank staff were provided by the trust's temporary staffing department. Some of the trust's permanent staff worked on the bank. Agency staff were used when bank staff were not available. We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. Most patients told us that there were sufficient number of staff on duty and there were always staff available in the communal areas of the wards.
- When we checked each wards duty rota for week commencing 18 May 2015, we observed that the safe staffing numbers were being achieved, though included the use of bank and agency staff.
- Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments. We were told that recruitment to vacant positions was ongoing and a number of newly qualified nurses had recently been appointed.
- We were informed, and found, that the recently appointed consultant psychiatrist had no junior doctor. However a full time staff grade was in post.
- The trust required staff to attend a variety of mandatory training courses. These included courses in basic life support, medical emergency response, observation of service users, fire safety, and people moving and handling. Training records showed us that 88% of staff had attended their mandatory training.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff told us that measures were put in place to ensure that any risk was managed. For example, the level and frequency of observations of patients by staff was increased. The individualised risk assessments we reviewed had taken into account the patients' previous history as well as their current mental state, and were detailed. Patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were updated at ward reviews, care programme approach (CPA) meetings or after an incident.
- 100% of staff had completed safeguarding vulnerable adults training and 96% of staff had safeguarding vulnerable children training. Staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns. This included the trust's, 'stop the line' initiative where staff were able to email the stop the line mailbox or contact the manager on call if they had immediate concerns about patient safety or the quality of care provided. Potential safeguarding concerns were discussed at the team meeting and we saw posters providing information about safeguarding.
- We saw the trust had comprehensive and up to date policies and procedures in place in relation to safeguarding adults and children.
- Prior to our inspection, the trust told us that there were no incidents of the use of seclusion between April 2014 and March 2015.
- The trust provided information stating there had been 58 incidents of use of restraint between August 2014 and February 2015. Of these, 29 patients (representing 50% of incidents) were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Each incident of restraint was recorded using the trust's incident reporting system. Most prone restraints were for administration of rapid tranquilisation.
- We found that 96% of the staff working within the acute wards had received training in physical intervention (patient restraint).
- We found one blanket restriction. There was a restriction that access to the garden was only permitted after midnight, on a one patient basis with an escorting member of staff. A ward manager explained that this was on the grounds of patient safety.

Track record on safety

- The incident reporting system was up to date and relevant to the wards. From the information provided by the trust, we saw that there had been 488 incidents recorded in past 12 months prior to our inspection. Of

these, 52% of incidents resulted in no harm to the patient, whereas 35% resulted in low harm, 13% resulted in moderate harm and 0.5% resulted in severe harm. The severe harm was an attempted suicide and an incident of self harm.

Reporting incidents and learning from when things go wrong

- Following an incident, improvements to ligature risks had been made by the replacing of bathroom doors on Springbank ward. Similar work was planned for the remaining wards.
- Staff we spoke with were able to describe the electronic system to report incidents and their role in the reporting process. We saw each ward had access to an online electronic system to report and record incidents and near misses.
- Staff were able to describe the various examples of serious incidents which had occurred within the wards. The trust told us that there was a local governance process in place to review incidents. Discussions had occurred locally at monthly team meetings about trust-wide incidents. There were weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients, and how these risks should be managed.
- On five of the wards, staff described receiving support and debriefing from within their team following any serious incidents. On Springbank ward, staff told us that the opportunity for a debrief was often missed.
- Each of the ward managers we spoke with told us how they provided feedback in relation to learning from incidents to their teams.
- We were given six examples of the use of the INA this year. In one specific case, it was used for a patient who was informal: we could find no evidence of consideration being given for a MHA assessment. When we asked to review the relevant incident form, it initially could not be located. However, once it was located we noted that the incident had not been classified as a serious incident and there was no record of any review, learning, recommendations or actions. We immediately raised our concerns with a senior member of staff, and the ward manager.

Psychiatric intensive care unit

Safe and clean ward environment

- The environment was clean and tidy, in a good state of repair and offered an environment conducive for mental health recovery. The ward layout allowed staff to observe most parts of the ward. Where this was not possible due to corners, mirrors had been mounted in the corners to aid observation. We saw a completed environmental risk assessments for the ward. This was regularly updated.
- The ward had undertaken, and updated when necessary, a ligature risk assessment. There were minimal ligature points on the ward, however some did exist and had been identified in the risk assessment. Control measures in place, to minimise the risk to patients, included the use of nursing observations. However, we were concerned that patients could potentially access the ligature points particularly during the night when there were only one qualified nurse and two healthcare assistants on duty. There was no seclusion room. We were told that environmental work was planned to ensure the ward met the standards advised by the national association of psychiatric intensive care and low secure units. This included the development of an 'airlock' entry to the ward and the removal of some of the ligature risks. Staff were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed. The ward had ligature cutters available and accessible in the event of an emergency occurring.
- There was no seclusion room on Poplar ward. Because of this, patients who needed to be cared for in seclusion were transferred to an out of area hospital with a seclusion facility. However, we heard that in an emergency a patient might have to be secluded in their bedroom. We were given an example about this happening and we reviewed this information. We found the reporting of the incident was thorough, and the ward manager had put the lack of seclusion facilities on the ward risk register. We saw that staff had managed the situation in the most appropriate way they could. However, secluding a patient in their bedroom does not meet the requirements of the MHA Code of Practice.
- Call bells for patients to use to attract the attention of the staff were not available in bedrooms. They were available in each bathroom and shower room to enable patients to summon assistance.
- Practices were in place to ensure infection control and staff had access to protective personal equipment such

as gloves and aprons. The ward was clean and tidy and we were told by staff the cleaning services were good. Training records showed us that 100% of staff had received training in infection prevention and control.

- There was a fully equipped clinical room. We saw the temperature of the room was monitored and recorded on a daily basis. Medicines were stored securely. Records showed that fridge temperatures were recorded daily. We saw fridge temperatures were within the required range. When we looked at the prescription and medicine administration records for four patients, we saw appropriate arrangements were in place for recording the administration of medicines. The records showed patients were receiving their medicines when they needed them. If patients were allergic to any medicines this was recorded on their medication administration record.
- Poplar ward had resuscitation equipment which was kept clean and tidy. We found the equipment was checked on a daily basis. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.
- The garden provided an area for patients to access fresh air. The garden appeared well maintained and had sufficient garden furniture available. There was a covered area available for patients to use during inclement weather. The garden had a high fence, but it was not totally secure. We were told by the ward manager that a patient had recently climbed over the fence and absconded

Safe staffing

- Staff told us that there were generally enough staff on duty to meet the needs of the patients.
- From the information the trust provided us, 425 hours, for qualified staff, had been requested from temporary staffing department between November 2014 and April 2015. We noted that 55% of the hours had been filled by bank staff, and 35% by agency staff. 10% of the requested shifts remained unfilled, which meant that the wards operated short of staff, or the ward manager or matron would undertake the shift. We also saw that 2544 hours, for unqualified staff, had been requested from temporary staffing department. We noted that 61.5% of the hours had been filled by bank staff, and 32% by agency staff. 6% of the requested hours remained unfilled.
- The ward manager told us that they are able to adjust staffing levels daily to take into account increased clinical needs. This included, for example, increased level of observation or patient escort. Some requested hours were due to staff sickness and existing staff sickness and vacancies. The average staff vacancy rate, for Poplar ward, between April 2014 and March 2015, was 3%. The average staff turn-over rate for the same time period was 1%.
- Escorted leave or ward activities were not cancelled due to shortage of staff.
- Bank staff were provided by the trust's temporary staffing department. Some of the trust's permanent staff worked on the bank. Where this department were unable to provide bank staff, agency staff were used as an alternative measure. Bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. This was signed off by the nurse in charge of the shift. We saw some examples of these completed forms.
- Most patients told us that there were sufficient number of staff on duty and there were always staff available in the communal area of the ward. However, we were concerned that patients could potentially access the ligature points particularly during the night when there were only one qualified nurse and two healthcare assistants on duty.
- When we checked ward's duty rota for week commencing 18 May 2015, we observed that the safe staffing numbers were being achieved.
- Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments.
- The trust required staff to attend a variety of mandatory training courses. These included courses in basic life support, medical emergency response, observation of service users, fire safety, and people moving and handling. Training records showed us that 90% of staff had attended their mandatory training.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff told us that, where particular risks were identified, such as a risk to self or to others, measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. The individualised risk assessments we

Requires improvement

Are services safe?

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

reviewed had taken into account the patients' previous history as well as their current mental state, and were detailed. Patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were updated at ward reviews, CPA meetings or after an incident.

- 100% of staff had completed safeguarding vulnerable adults training and 95.5% of staff had safeguarding vulnerable children training. Staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns. This included the trust's 'stop the line' initiative where staff were able to email the stop the line mailbox or contact the manager on call if they had immediate concerns about patient safety or the quality of care provided. Potential safeguarding concerns were discussed at the team meeting and we saw posters providing information about safeguarding.
- We saw the trust had comprehensive and up to date policies and procedures in place in relation to safeguarding adults and children.
- The trust provided information, prior to our inspection, stating there had been no incidents of the use of seclusion between April 2014 and March 2015.
- We found that 100% of the staff working within the Poplar ward had received training in physical intervention (patient restraint).
- We found one blanket restriction. Poplar ward did not allow patients access to the kitchen to make drinks due to the severity of the patients' mental health problems. Both staff and patients told us that patients would be provided drinks outside of a schedule at their request and that this was always granted

Track record on safety

- The trust provided information stating there had been 13 incidents of use of restraint between August 2014 and February 2015. Of these, 9 patients (representing 69% of incidents) were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Each incident of restraint was recorded using the trust's incident reporting system.

Reporting incidents and learning from when things go wrong

- Staff told us they could raise concerns for inclusion on the trust risk register.
- The trust reported identified concerns through the national reporting and learning system and other national reporting mechanisms.
- Information about adverse events and incidents around the trust was shared through a whole acute service governance meeting. There was also a page on the trust's intranet that staff could access to view details and recommendations of lessons learnt from incidents.
- Staff we spoke with were able to describe the electronic system to report incidents and their role in the reporting process. The ward had access to an online electronic system to report and record incidents and near misses.
- Staff were able to describe the various examples of serious incidents which had occurred within the ward. The trust told us that there was a local governance process in place to review incidents.
- Discussions had occurred locally at monthly team meetings about trust-wide incidents. There were weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients, and how these risks should be managed.
- The ward manager told us how they provided feedback in relation to learning from incidents to their teams.

Are services effective?

Good

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

Our findings

Acute wards

Assessment of needs and planning of care

- Patients' needs were assessed and care and treatment was planned to meet identified needs. We looked at 26 care records for patients receiving care and treatment and saw that these contained up to date care plans that gave information to staff about how best to care for the patient. We found the care plans to be detailed, individualised to the patients' needs and showing the patients' involvement in the care planning process.
- An electronic record system operated across the trust. Information, contained within this system, could be shared between the wards, home treatment teams and other community teams.
- Patients' physical health needs were identified. Patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were met. Physical health examinations and assessments were documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems were taking place. The records we saw included a care plan which provided staff with clear details of how to meet patients' physical needs.

Best practice in treatment and care

- Patients were receiving regular one to one time with their named nurse and we saw evidence of this in the care records.
- We saw multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the care plan was achieving the desired outcome for patients.
- Each ward had a range of range of leaflets covering a variety of informative topics, such as relapse prevention, goal setting, problem solving, weight loss, complaints and the patient advice and liaison service.
- On Springbank ward, psychological therapies such as cognitive behavioural therapy and dialectic behavioural therapy were offered to patients. There was an absence of psychology on Mulberry 1 and Mulberry 2 wards, as the permanent post holder had left and the assistant psychologist was working on Springbank ward. We were told that the vacant position was being recruited to. There was a psychologist available and easily accessible for Oak 1, Oak 2 and Oak 3 wards.
- Access to physical healthcare such as podiatrists and dentists were made through referrals through primary medical services. The ward had access to other allied health professionals, such as occupational therapists and physiotherapists, who were employed directly by the trust.
- We received mixed feedback from the patients we spoke with about the quality of the care and treatment they had received. Overall, the feedback was positive.
- Outcomes for patients receiving care and treatment on the wards were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation.
- We found that a nationally recognised rating scale to assess and record severity and outcomes, for example, Health of the National Outcome Scales was being used on the wards we visited.
- Each ward we inspected offered a range of on-the-ward activities. These included, for example, the daily community meetings, wellness and recovery groups, cardio-fitness, arts and crafts, and baking. We observed a number of activities and saw a calm and happy atmosphere, with patients engaging in and enjoying the activities. Patients told us that they felt there were sufficient activities available on the wards, though some patients had chosen not to participate in the activities offered.
- In the Cavell Centre (where Oak 1, Oak 2 and Oaks 3 wards are located, along with some other wards from other core services), we saw facilities such as a gymnasium, a treatment suite and other various space for meetings with psychologists and occupational therapists. These were being utilised well during our inspection.

Skilled staff to deliver care

- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone. A number of newly qualified nurses told us of a well-

Are services effective?

Good

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

structured and in-depth preceptorship programme. Preceptorship is a period of time in which to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.

- We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. This was signed off by the nurse in charge of the shift. We saw some examples of these completed forms.
- Staff had access to supervision. We saw examples of completed supervision records. Whilst the majority of wards were good, staff on Springbank ward told us that access to supervision was poor. In addition to the recorded supervision, ward managers and staff told us that informal supervision took place regularly.
- We saw 100% of staff had an up to date appraisal and personal development plan in place at the time of our inspection.
- Staff told us there were regular team meetings and they felt supported by their peers and immediate managers. Staff also told us they enjoyed good team working as a positive aspect of their work on the wards.
- The ward managers explained to us that staff performance issues, when identified, were addressed promptly and effectively. We were given an example of this.

Multi-disciplinary and inter-agency team work

- We observed a lunch-time nursing staff handover. The handover was structured and covered information such as observations, risk, general and mental health and social issues. We also observed a multi-disciplinary meeting during our inspection and found this effective in enabling staff to share information about patients and review their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- We were concerned that the nursing handover from the night shift to the day shift, and vice versa, on all wards was only 15 minutes in length. Some staff told us that they would often finish their shift and then need to telephone the ward to hand a piece of information over which they had missed in the formal handover.
- Occupational therapists worked as part of ward teams and we saw that they worked closely with patients in assessing their needs and being involved in the care and therapy offered. The patients we talked with spoke positively about this.
- The consultant psychiatrist and other medical staff were a regular presence on the wards and were present at times during our inspection. We observed good interaction between the ward staff and medical teams on the wards.
- We saw how community teams were invited to and attended discharge planning meetings, and patients we spoke with told us these were supportive.

Adherence to the MHA and MHA Code of Practice

- We checked whether systems were in place to ensure compliance with the Mental Health Act 1983 (MHA) and adherence to the guiding principles of the MHA Code of Practice. We found examples of discrepancies in relation to this.
- On Springbank ward, we found evidence to show that errors had been made in relation to the consent to treatment under the MHA and the prescribing of medication. Five patients' prescriptions had mistakes between what was documented on their T2 form (the certificate to consent to treatment, under section 58 of the MHA) and what medicines patients had been prescribed.
- We saw posters were displayed informing patients of how to contact the independent mental health advocate (IMHA). We also saw information for patients who were detained under the MHA about how they could contact the CQC.
- There was a clear process for scrutinising and checking the receipt of MHA documentation. We found overall that the MHA record keeping and scrutiny was satisfactory.
- Training records showed us that 84% of staff members working had received training in the MHA. This training recurred on a three yearly basis. When we spoke with staff they demonstrated a working knowledge of the MHA.

Good practice in applying the MCA

Are services effective?

Good

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

- We saw that 87% of staff members working had received training in the Mental Capacity Act (MCA). This training recurred on a three yearly basis. When we spoke with staff, they demonstrated a working knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).
- None of the patients receiving care and treatment during our inspection were under a DOLS.
- Records we sampled showed that patients' mental capacity to consent to their care and treatment was always assessed on their admission or an ongoing basis. However, the quality of these assessments varied from one sentence confirming whether or not a patient had capacity, to a comprehensively documented MCA assessment.

Psychiatric intensive care unit

Assessment of needs and planning of care

- Patients' needs were assessed and care and treatment was planned to meet identified needs. We looked at four care records for patients receiving care and treatment and saw that these contained up to date care plans that gave information to staff about how best to care for the patient. We found the care plans to be detailed and individualised to the patients' needs.
- An electronic record system operated across the trust. Information, contained within this system, could be shared between the wards, home treatment teams and other community teams.
- Patients' physical health needs were identified. Patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were met. Physical health examinations and assessments were documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems was taking place. The records we saw included a care plan which provided staff with clear details of how to meet patients' physical needs.
- In the care records, we found three instances where rapid tranquilisation had been given to patients. In each case there was evidence that physical observations, following the rapid tranquillisation, had been carried out in accordance with the trust policy.

Best practice in treatment and care

- Patients were receiving regular one to one time with their named nurse and we saw evidence in the care records to show that this was the case.
- We saw multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the care plan was achieving the desired outcome for patients.
- The ward had a range of range of leaflets covering a variety of informative topics, such as relapse prevention, goal setting, problem solving, weight loss, complaints and the patient advice and liaison service.
- There was a psychologist available and easily accessible. Patients on the wards were seen swiftly by the psychologist.
- Access to physical healthcare such as podiatrists and dentists were made through referrals through primary medical services. The ward had access to other allied health professionals, such as occupational therapists and physiotherapists, who were employed directly by the trust.
- We received positive feedback from the patients we spoke with about the quality of the care and treatment they had received.
- Outcomes for patients receiving care and treatment on the ward were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation.
- We found that nationally recognised rating scales to assess and record severity and outcomes, for example, Health of the National Outcome Scales were being used.
- Poplar ward offered a range of on-the-ward activities. These included, for example, the daily community meetings, wellness and recovery groups, cardio-fitness, arts and crafts, and baking. We observed activities taking place and saw a calm and happy atmosphere, with patients engaging in and enjoying the activities. Patients told us that they felt there were a sufficient amount of activities available on the wards and activities were not cancelled due to a shortage of staff.
- In the Cavell Centre (where Poplar ward is located, along with some other wards from other core services), we saw facilities such as a gymnasium, a treatment suite and other various space for meetings with psychologists and occupational therapists. These were being utilised well during our inspection.

Skilled staff to deliver care

Are services effective?

Good

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

- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone. A number of newly qualified nurses told us of a well-structured and in-depth preceptorship programme. Preceptorship is a period of time in which to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.
- Bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks. This was signed off by the nurse in charge of the shift. We saw some examples of these completed forms.
- Staff had access to supervision. We saw good examples of supervision records. In addition to the recorded supervision, the ward manager and staff told us that informal supervision took place regularly.
- We saw 100% of staff had an up to date appraisal and personal development plan in place at the time of our inspection.
- Staff described receiving support and debriefing from within their team following any serious incidents.
- There were regular team meetings and staff reported that they felt supported by their peers and immediate managers. Staff also told us they enjoyed good team working as a positive aspect of their work on the wards.
- The ward manager explained to us that staff performance issues, when identified, were addressed promptly and effectively. We were given an example of this.

Multi-disciplinary and inter-agency team work

- We observed a lunch-time nursing staff handover. The handover was structured and covered information such as observations, risk, general and mental health and social issues. We observed a multi-disciplinary meeting on Poplar Ward. In attendance were medical staff, pharmacy, nurses and psychologists. Patients attended the multi-disciplinary meeting and staff were professional and courteous towards them.
- We were concerned that the nursing handover from the night shift to the day shift, and vice versa, on Poplar ward was only 15 minutes in length. We were told by members of staff that the reduction in the handover time was due to the trust's cost improvement programme. However, we saw the midday nursing handover was lengthy and comprehensive covering, for example, risk, observations, legal status, history, presenting factors and plans.
- Occupational therapists worked as part of ward team and we saw that they worked closely with patients in assessing their needs and being involved in the care and therapy offered. The patients we talked with spoke positively about this.
- The consultant and medical staff were a regular presence on the ward and were present at times during our inspection. We observed good interaction between the ward staff and medical teams on Poplar ward.
- The psychologist told us that they provided reflection time and some training for staff. In addition they had plans to start some work with families.

Adherence to the MHA and MHA Code of Practice

- We checked whether systems were in place to ensure compliance with the Mental Health Act 1983 (MHA) and adherence to the guiding principles of the MHA Code of Practice. We found examples of discrepancies in relation to this. Detention papers were available for inspection and we found these to be in good order. However, for one patient, there was no approved mental health professional (AMHP) report. We drew this to the attention of the MHA team, who provided evidence that a reminder had already been requested.
- Leave was authorised following risk assessments. We observed that authorisations were checked before allowing a patient to leave the ward. Patients were not given a copy of their Section 17 form as, the ward manager explained, all leave was escorted.
- We saw posters were displayed informing patients of how to contact the independent mental health advocate (IMHA). We also saw information for patients who were detained under the MHA about how they could contact the CQC.
- All treatment appeared to have been given under an appropriate legal authority. We saw evidence that patients were informed about their rights on admission and reminded about them appropriately.
- There was a clear process for scrutinising and checking the receipt of MHA documentation. We found overall that the MHA record keeping and scrutiny was satisfactory.

Are services effective?

Good

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

- Training records showed us that 90% of staff members working had received training in the MHA. This training recurred on a three yearly basis. When we spoke with staff they demonstrated a working knowledge of the MHA.

Good practice in applying the MCA

- We saw that 92% of staff members working had received training in the Mental Capacity Act 2005 (MCA). This training recurred on a three yearly basis. When we spoke with staff, they demonstrated a working knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).
- None of the patients receiving care and treatment during our inspection were under a DOLS.
- Records we sampled showed that patients' mental capacity to consent to their care and treatment was always assessed on their admission or an ongoing basis. However, the quality of these assessments varied from one sentence confirming whether or not a patient had capacity, to a comprehensively documented MCA assessment.

Good

Are services caring?

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

Our findings

Acute wards

Kindness, dignity, respect and support

- We spoke with 24 patients receiving care and treatment. We observed how staff interacted with patients throughout the three days of our inspection. Staff appeared kind with caring and compassionate attitudes. We observed many examples of staff treating patients with care and compassion. We saw staff engaging with patients in a kind and respectful manner on all of the wards.
- We observed that patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed staff knocked before entering patients' rooms, and speaking positively with patients.
- Staff were visible in the communal ward areas and attentive to the needs of the patients they cared for. Patients we spoke with were positive about the staff in relation to the respect and kindness they showed to them.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.

The involvement of patients in the care they receive

- Patients told us that they were involved in their care planning and reviews to varying degrees. Records confirmed this. The majority of patients told us they had been actively involved in planning their care. However, one patient on both Oak 1 and Oak 2 wards told us that they had not been. We saw that patients' views were clearly evident in their care plans. Patients were invited to the multi-disciplinary reviews along with their family where appropriate.
- We observed information boards across the wards detailing the staff that were on duty and what staffing levels the wards should be on, to highlight to the patients receiving services what staffing resources were available that day. This helped everyone on the wards to understand how best to facilitate each patients' plans for the day.
- Community meetings were held every morning including at the weekends. This meeting was usually chaired by patients and was attended by, when available, the ward manager, occupational therapist, psychological and medical staff. Minutes were taken and we saw evidence of actions of concerns that were raised being completed.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were in operation. We found there was a sufficient amount of dedicated space for patients to see their visitors. There were specific children's visiting areas for each ward.
- Patients had access to a local advocacy service including an independent mental health advocate and there was information on the notice boards on how to access this service.

Psychiatric intensive care unit

Kindness, dignity, respect and support

- We spoke with four patients receiving care and treatment. We observed how staff interacted with patients throughout our inspection of Poplar ward. Staff appeared kind with caring and compassionate attitudes. We observed many examples of staff treating patients with care and compassion. We saw staff engaging with patients in a kind and respectful manner.
- We observed that patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed staff knocked before entering patients' rooms, and speaking positively with patients.
- Staff were visible in the communal ward areas and attentive to the needs of the patients they cared for. Patients we spoke with were positive about the staff in relation to the respect and kindness they showed to them.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.

The involvement of patients in the care they receive

- Patients told us that they were involved in their care planning and reviews to varying degrees. The four care records we sampled confirmed this. The majority of patients told us they had been actively involved in planning their care. However, one patient was unable to recollect information about their care plan. We saw that patients' views were clearly evident in their care plans. Patients were invited to the multi-disciplinary reviews along with their family where appropriate.

Good

Are services caring?

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

- We observed information boards on the ward detailing the staff that were on duty and what staffing levels the wards should be on, to highlight to the patients receiving services what staffing resources were available that day. This helped everyone on the ward to understand how best to facilitate each patients' plans for the day.
- We saw an example of a comments box entitled "no" on Poplar ward. Patients could write their comments and place them in the box if they felt they had been unfairly responded to when placing a request of any nature. The comments would then be discussed at the community meeting or with the ward manager. We saw evidence of these discussions.
- Community meetings were held every morning including at the weekends. This meeting was usually chaired by patients and was attended by, when available, the ward manager, occupational therapist, psychological and medical staff. Minutes were taken and we saw evidence of actions of concerns that were raised being completed.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were in operation. We found there was a sufficient amount of dedicated space for patients to see their visitors. There was a specific children's visiting area available for Poplar ward.
- Patients had access to a local advocacy service including an independent mental health advocate and there was information on the notice boards on how to access this service.

Are services responsive to people's needs?

Good

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

Our findings

Acute wards

Access, discharge and bed management

- The trust operated a '3-3-3' pathway model of assessment, treatment and recovery. The model consists of three stages of care, namely three days of assessment, three weeks of treatment and three months of recovery. Each ward had a designated function. For example, Oak 3 ward was for admissions for specialist assessment within 72 hours, resulting in either recommendation for admission to another ward for treatment and/or recovery, transfer of care to the crisis resolution and home treatment team, to the general practitioner (GP), or to a community team or agency. The ward managers confirmed that this system worked, although there could be short delays in transferring patients between wards. Springbank ward was not included in this pathway model, as it provided a specialist service for women aged 18 years old and over, with a diagnosis of borderline personality disorder.
- There were a number of beds available for admission of patients. There were a total of 67 patients receiving care and treatment within the wards, with a further 19 beds available for patient admissions. This meant that the bed occupancy rate on the day of our inspection was 78%.
- The ward managers confirmed there was always access to a bed on when a patient returns from a period of leave and patients always returned to their own bedroom.
- There was a morning meeting in which senior staff would meet to discuss issues relating to bed management, and any other issues.
- The ward managers told us that a new position had been created in relation to housing and accommodation needs of patients to facilitate early discharge.
- Staff told us there could occasionally be delays if patients needed to be transferred to the psychiatric intensive care unit (PICU), if there were no beds immediately available there.

The ward environment optimises recovery, comfort and dignity

- We found all of the wards offered an environment conducive for mental health recovery. The environments were spacious, pleasantly decorated and calming.
- We saw that patients had lockers to place valuables in. However, patients did not have a key to their lockers, so had to approach a member of staff. This was for all patients and not based on individual risk assessments. Patients were however able to lock their bedroom doors using an electronic operated bracelet.
- Each ward had a lounge (including female lounges on mixed sex wards) and dining areas, bedrooms (with ensuite facilities), quiet areas, interview and meeting rooms, and offices. With the exception of Mulberry 2 ward where we saw two double bedrooms, all other wards had single bedroom accommodation. Patients were able to lock their bedroom doors, using an electronic bracelet. Lockers were available in each bedroom for the storage of valuables, though the staff held the keys for the lockers. We saw patients had, in some instances, personalised their own bedrooms with pictures of families, bedding and the use of wall art. For example, on Springbank ward, one patient had crafted handmade rugs for the other patients. The rugs were in their rooms.
- Throughout the wards, we saw information displayed on bedroom doors relating to managing privacy and dignity, with the patients' consent, giving information such as how the patient wanted to be checked during the night (for example, through the viewing panel in the door, or by a member of staff entering the room) and the choice of drink they wished to be served when they were awoken in the morning.
- We saw that patients were able to make private telephone calls, either using their own mobile telephone or the ward telephone.
- Patients had access to outside space, which was either a well maintained garden or courtyard. These areas also provided suitable shelter for patients wishing to smoke during inclement weather.
- A 'cook chill' food system was in operation on the wards. We saw that there was a range of menu choices. However, patients had mixed views about the quality of the food. Half of the patients we spoke with told us the food was satisfactory, whilst the remainder felt the food could be improved. Patients could make hot drinks and snacks 24 hours a day, seven days a week.

Are services responsive to people's needs?

Good

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

Meeting the needs of all patients who use the service

- There were facilities available for patients with mobility difficulties who required disabled access with assisted bathroom space, wide corridors and ramped access.
- Spiritual care and chaplaincy was provided when requested. For Oak 1, Oak 2 and Oak 3 wards, we saw there was a well-equipped and pleasant designated area for prayer and multi-faith worship. There was a range of religious artefacts available and an ablution room in the communal hub area of the building. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- We saw a range information leaflets available, some of which were written in languages, other than English, spoken by patients**.**
- Staff told us that interpreters were available using a local interpreting service or language line. These services had been used previously to assist in assessing patients' needs and explaining their care and treatment.

Listening to and learning from concerns and complaints

- All the wards accessed the trust's complaints system. Information about the complaints process was displayed on posters and was also available as a leaflet. Patients we spoke with knew how to make a complaint.
- Staff were able to demonstrate verbally how to respond to patients complaints and what support was available for patients should they have any concerns, such as the patient advice and liaison service. Staff also knew whom they would seek guidance from within the trust in relation to complaints.
- Complaints were recorded using the trust's computerised incident reporting system. We how the issues were investigated, the outcomes and how learning was cascaded. The ward managers told us they shared learning amongst their staff via staff meetings and communications.

Psychiatric intensive care unit

Access, discharge and bed management

- There were a number of beds available for admission of patients. There were a total of four patients receiving care and treatment within the ward, with a further two beds available for patient admissions.
- There was a morning meeting in which senior staff would meet to discuss issues relating to bed management, and any other issues.

The ward environment optimises recovery, comfort and dignity

- We found the ward offered an environment conducive for mental health recovery. The environment was spacious, pleasantly decorated and calming.
- The ward offered a lounge and dining area, bedrooms (with ensuite facilities), quiet areas, interview and meeting rooms, offices, small gymnasium and art room. All bedrooms were for single patient occupancy. Patients were able to lock their bedroom doors, using an electronic bracelet. Poplar ward did not allow personal items in the bedrooms due to the severity of the patients' mental health problems and expected short admission within the ward.
- We saw information displayed on bedroom doors, with the patients' consent, giving information such as how the patient wanted to be checked during the night (for example, through the viewing panel in the door, or by a member of staff entering the room) and the choice of drink they wished to be served when they were awoken in the morning.
- We saw that patients were able to make private telephone calls using the ward telephone.
- Patients had access to outside space, which was a well maintained garden. This area also provided suitable shelter for patients wishing to smoke during inclement weather.
- A 'cook chill' food system was in operation on the ward. We saw that there was a range of menu choices, however patients told us the actual quality of the food could be improved.
- The ward had locks on the main entrances with entry and exit controlled by staff. Staff carried personal alarms. During our inspection, we were given personal alarms.

Meeting the needs of all patients who use the service

- There were facilities available for patients with mobility difficulties who required disabled access with assisted bathroom space, wide corridors and ramped access.
- Spiritual care and chaplaincy was provided when requested. We saw there was a well-equipped and pleasant designated area for prayer and worship. There was a range of religious artefacts available and an

Are services responsive to people's needs?

Good

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

ablution room in the communal hub area of the building. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

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Listening to and learning from concerns and complaints

- The ward accessed the trust's complaints system. Information about the complaints process was displayed on posters and was also available as a leaflet. Patients we spoke with knew how to make a complaint.
- Staff were able to demonstrate verbally how to respond to patients complaints and what support was available for patients should they have any concerns, such as the patient advice and liaison service. Staff also knew whom they would seek guidance from within the trust in relation to complaints.
- Complaints were recorded using the trust's computerised incident reporting system. We how the issues were investigated, the outcomes and how learning was cascaded. The ward managers told us they shared learning amongst their staff via staff meetings and communications.

Are services well-led?

Good

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

Our findings

Acute wards

Vision and values

- The staff told us they were aware of the trust's visions and values. We saw the trust's visions and values were displayed around the wards.
- Staff we spoke with were able to tell us on the day of our visit who the most senior managers in the trust were and these managers had visited the wards. We were told that the chief executive had worked shifts on a number of wards, for example, Oak 2 and Springbank wards.

Good Governance

- Governance committees and mechanisms were in place which supported the safe delivery of the service. The lines of communication, from the board and senior managers, to the frontline services were clear.
- Incidents were reported through Datix (the trust's electronic incident reporting system). We saw examples of records to show that this recording was effective, through reviewing individual specific events and incidents.
- We saw evidence of trust wide learning from incidents and complaints being shared with staff in order to change to practice.
- On two wards, namely Mulberry 2 and Springbank Ward, we had concerns about the governance of the Mental Health Act 1983. These included concerns about consent to treatment (Section 58) and practices amounting to the use of seclusion.
- On five of the six wards, we found that staff were receiving appraisals and regular supervision. However, on Springbank ward we found this was not on a consistent basis. The ward manager explained that this was due to staff vacancies within the ward and not having a full complement of staff in order to deliver regular supervision.
- The ward managers confirmed that they have sufficient authority to manage their ward and also received administrative support. They told us that they received a good level of support from their matron and general manager.
- We saw band 6 nursing staff (the deputy ward managers) were actively participating in clinical audit and were undertaking reviews of patient care plans.
- The trust had taken actions to address a breach in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 identified in the previous inspection of September 2013 at Fulbourn hospital.

Leadership, morale and staff engagement

- The wards appeared to be well managed, both on a day to day basis and strategically (for example, the wards had future plans of what they wanted to achieve).
- On Springbank ward, many staff told us that morale in the past across the service had been low, but had improved since the current ward manager had joined the ward in September 2014. On the remaining wards, staff told us that morale and job satisfaction were high, however staff said the manner in which shifts are arranged was not conducive to a good work life balance and this resulted in staff leaving the trust.
- We were impressed with the morale of the staff we spoke with during our inspection and found that the local teams were cohesive and enthusiastic.
- Staff we spoke with told us that they felt part of a team and received support from each other.
- The ward managers on all wards confirmed that there were no current cases of bullying and harassment involving the staff.
- All staff we spoke with said they felt well supported by their ward manager and matron and felt their work was valued by them. We saw a positive working culture within the teams which we inspected.

Commitment to quality improvement and innovation

- We saw that patients' views were gathered through feedback upon discharge. Information technology devices were used to facilitate this. We saw how these results were analysed by the individual ward managers to provide an overview of the service.
- Information provided by the trust confirmed that Oak 1 and Oak 2 wards were accredited through the royal college of psychiatrist's accreditation for inpatient mental health services (AIMS) programme. AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Oak 3, Mulberry 1 and Mulberry 2 were going through the accreditation process, and we were told by the ward manager of Springbank ward that their ward had been accredited.

Are services well-led?

Good

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.

- The ward managers and matrons were able to provide us with information on how the wards were performing and had a good understanding of where improvements were required. They were making improvements in the quality of the service.

Psychiatric intensive care unit

Vision and values

- The staff told us they were aware of the trust's visions and values. We saw the trust's visions and values were displayed around the wards.
- Staff we spoke with were able to tell us on the day of our visit who the most senior managers in the trust were and these managers had visited the wards. We were told that the chief executive had worked a shift on the ward.

Good Governance

- Governance committees and mechanisms were in place which supported the safe delivery of the service. The lines of communication, from the board and senior managers, to the frontline services were clear.
- Incidents were reported through Datix (the trust's electronic incident reporting system). We saw examples of records to show that this recording was effective, though reviewing individual specific events and incidents.
- We saw evidence of trust wide learning from incidents and complaints being shared with staff in order to change to practice.
- We found that staff were receiving appraisals and regular supervision.
- The ward manager confirmed that they have sufficient authority to manage their ward and also received administrative support. They told us that they received a good level of support from their matron and general manager.
- We saw band nursing 6 staff (the deputy ward managers) were actively participating in clinical audit and were undertaking reviews of patient care plans.

Leadership, morale and staff engagement

- The ward appeared to be well managed, both on a day to day basis and strategically (for example, the ward had future plans of what they wanted to achieve).
- Staff told us that morale and job satisfaction was good. We were impressed with the morale of the staff we spoke with during our inspection and found that the local teams were cohesive and enthusiastic. Staff we spoke with told us that they felt part of a team and received support from each other.
- The ward manager confirmed that there were no current cases of bullying and harassment involving the staff.
- All staff we spoke with said they felt well supported by their ward manager and matron and felt their work was valued by them. We saw a positive working culture.

Commitment to quality improvement and innovation

- We saw that patients' views were gathered through feedback upon discharge. We saw how these results were analysed by the ward manager to provide an overview of the service.
- Information provided by the trust confirmed that Poplar ward had deferred the royal college of psychiatrist's accreditation for inpatient mental health services (AIMS) programme, due to the absence of an air-lock system at the entrance of the ward. Once the work was completed, it was the intention to pursue the AIMS programme. AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards.
- The ward manager were able to provide us with information on how the ward was performing and had a good understanding of where improvements were required. They were making improvements in the quality of the service.