Good

Pennine Care NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Date of inspection visit: 14-16 June 2016
Date of publication: 09/12/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT210	Heathfield House - Specialist Services Division	Heathfield House	SK2 6RA
RT2X9	Rhodes Place	Rhodes Place	OL4 5PL
RT243	Stansfield Place	Stansfield Place	OL16 5PX
RT205	Stockport Mental Health Services	Bevan Place	SK2 7JE
RT202	Tameside Mental Health Services	Beckett Place	OL6 9RW
RT202	Tameside Mental Health Services	Hurst Place	OL6 9RW

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Pennine Care 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 Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care 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?	Good
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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Overall summary

We rated Pennine Care NHS Foundation Trust as **good** because:

- Patients had an ongoing risk assessment and a comprehensive assessment of their needs. Patient involvement in their care planning was variable. However, this was improving following the introduction of "My Shared Pathway", a nationally recognised person centred care planning tool developed collaboratively by patients and professionals.
- The multidisciplinary team routinely reviewed patients' care. Patients had a care programme approach (CPA) meeting every six months.
- There were rehabilitation and discharge care pathways for patients that lasted from two to five years. Some patients with complex or treatment resistant illnesses were in hospital for longer. However, staff continued to engage with them to work towards moving on from the service, but outside the pathway timeframes.
- Patients had their physical healthcare needs met.
- Staff were familiar with the principles of least restrictive practice. This was an ongoing piece of work, but restrictions within the service were under review. These balanced least restrictive practice against risks presented to patients and other people.
- Medication was managed and administered correctly. Some patients administered their own medication and there were clear stages for patients to work through at their own pace.
- The environment was clean and maintained. Environmental risk assessments had been removed, and risks to patients had been removed, or were mitigated against.
- Managers and senior clinicians met regularly and reviewed information about the safety and quality of the service. This included reviewing incidents and complaints, in addition to new initiatives and guidance. When actions were required, action plans were followed up at the meetings. Information was passed to ward staff through team meetings, emails and supervision.
- Staff had completed most of their mandatory training.
- The Mental Health Act and Mental Capacity Act were implemented effectively.
- Psychology input was provided on all the wards, but was a limited resource so focused on providing support and advice to staff, with one or two sessions with individuals and groups.
- There was an occupational therapy or technical instructor on all the wards. They provided an activity programme, and the occupational therapists carried out assessments of patients.
- There were nursing and health care assistant vacancies. These were filled by bank and agency staff, and there was ongoing recruitment.
- All patients had their own room. Some wards had ensuite bathrooms and others had shared facilities. Patients had access to food and drink, and some patients prepared their own meals.

However:

- Patients had an ongoing complaint about the lack of choice and poor quality of the food on some of the wards. External companies supplied meals.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- The environment was clean and maintained. Environmental risk assessments had been carried out, and risks to patients had been removed, or were mitigated against. The wards were compliant with guidance on mixed gender accommodation. Staff carried emergency alarms, and there was equipment for use in the event of a medical emergency. Staff carried out routine checks of patients and the environment throughout the day.
- Staff at all levels were aware of least restrictive practice, and restrictions within the service were under ongoing review. These balanced least restrictive practice against risks presented to patients and other people.
- Restraint and rapid tranquilisation were rarely used. There were no seclusion facilities, and the service did not use seclusion or long-term segregation.
- Medication was managed and administered correctly. Some patients administered their own medication and there were clear stages for patients to work through at their own pace.
- Staff reported incidents, and managers and relevant departments within the trust reviewed these. Incident information was collated and reviewed at a monthly governance meeting, and actions were followed through. Information about incidents was shared across the trust.
- Staff had completed most of their mandatory training. There were medical staff available throughout the night and day.

However:

- There were nursing and health care assistant vacancies, but these were filled by bank and agency staff, and there was ongoing recruitment.

Are services effective?

Good

We rated effective as **good** because:

- All patients had a comprehensive assessment carried out before and after their admission. This included risk and physical healthcare, in addition to their mental health and

Summary of findings

social needs. The service had recently started a six month programme to implement “My Shared Pathway”, a nationally recognised person centred care planning tool developed collaboratively by patients and professionals.

- The multidisciplinary team reviewed patients’ care regularly. All patients had a care programme approach meeting (CPA) to discuss their care and discharge planning every six months.
- Occupational therapy, psychology and pharmacy input was available on all the wards.
- Patients had their physical healthcare needs met.
- The Mental Health Act and Mental Capacity Act were implemented effectively.
- Psychologists were available, and their primary role was promoting a psychologically-minded approach and advising and supporting staff. They provided some groups and individual sessions with patients, which had a positive impact, but this was limited by the number of psychologists available.

However:

Staff had an understanding of the Mental Health Act and Mental Capacity Act but it was not clear what training they had had to support this, as it was not mandatory within the trust.

Are services caring?

Good

We rated caring as **good** because:

- The service had introduced collaborative care planning tools so that patients were involved in developing their care plan with staff.
- The interactions we saw between patients and staff were friendly and respectful. Staff were responsive to patients, and understood their needs.
- All the wards had weekly community meetings for patients to raise their concerns. Information about the service was on display on the wards.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- There were rehabilitation and discharge care pathways for patients, which outlined their progress through the service. There was a positive transfer pathway for male and female patients through the wards. There were also patients who had

Summary of findings

been on the wards longer than the pathways, due to complex or treatment resistant illness. These patients were still supported and rehabilitation and discharge was still the goal to work towards.

- There was no waiting list, and patients were able to access a bed when required. Patients' beds were not used when they went on leave. Patients had their own bedrooms, which they had personalised.
- There were adequate facilities on the wards. An activity programme was provided throughout the week.
- Interpreters were provided when required, and diets to meet religious or cultural needs were available. These included halal and vegetarian meals.
- Patients could access food and drinks throughout the day. Some patients cooked some of their own meals, and there were kitchens on the ward for patients to do this.
- Patients and staff were aware of how to make a complaint. The service had low numbers of complaints.

However:

- Patients were unhappy about the choice and quality of the food on some of the wards and had established a group to raise their concerns.

Are services well-led?

Good

We rated well led as **good** because:

- Managers and senior clinicians met regularly collected and reviewed information about the safety and quality of the service. This included incidents, environmental risks, and complaints. They took action to address areas of concern and implemented improvements. Key information from these reviews was shared with staff.
- Managers collected and reviewed information about staff, which included resources, supervision and training. They took action to address gaps.
- The service had been reconfigured 18 months prior to the inspection, and there had been subsequent changes to the service and staffing. Staff said there had been difficult periods, but they were mostly positive about the changes, and felt this had led to improvements for staff and patients. Most staff were positive about the teams they worked in and the support they received from managers.

Summary of findings

Information about the service

The trust provides long stay and rehabilitation services through its Rehabilitation and High Support Directorate.

There are six step-down rehabilitation units: Beckett Place and Hurst Place are in the grounds of Tameside General Hospital. Bevan Place is in the grounds of Stepping Hill Hospital in Stockport, and Heathfield House is a standalone unit in Stockport. Rhodes Place is a standalone unit in Oldham, and Stansfield Place is a standalone unit in Rochdale.

- Bevan Place is for up to 16 men aged over 50 years
- Heathfield House is for up to 19 men of working age (18-65 years), and also has three self-contained studio flats
- Hurst Place is for up to 15 men of working age.
- Beckett Place is for up to 10 women of working age
- Rhodes Place is for up to eight women of working age.
- Stansfield Place is a mixed gender ward. It has shared communal facilities, with separate sleeping areas for up to six men and six women.

Some of the wards may admit patients from across the North West or other parts of the country. However, most patients are admitted from across the trust's main catchment area, which covers Bury, Oldham, Stockport, Tameside and Rochdale.

Our inspection team

Our inspection team was led by:

Chair: Aiden Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust

Head of Hospitals: Nicholas Smith, Care Quality Commission (CQC)

Team Leaders: Sharron Haworth (mental health) and Julie Hughes (community health), Inspection Managers, CQC

The team that inspected long stay/rehabilitation mental health wards comprised a CQC inspector, a nurse, a social worker and a CQC pharmacy inspector.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all six of the wards across five sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 12 patients
- spoke with the managers or acting managers for each of the wards

Summary of findings

- spoke with 31 other staff members; including doctors, nurses, occupational therapists, a pharmacist, and psychologists
- spoke with the directorate manager, clinical service mangers, and the clinical governance manager with responsibility for these services
- attended and observed a hand-over meeting
- collected feedback from 2 patients using comment cards
- looked at 22 care records of patients, and other clinical records including prescription charts and physical healthcare checks
- looked at how medication was managed on each ward, and carried out a specific check of the medication management on one ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 12 patients.

Patients told us that most of the staff were helpful and supportive.

Patients gave a mixed picture of how involved they were in their care. Some patients said they were very involved and described their plan in details. Others said they had limited involvement and that decisions were made for them. The service had recently started to implement an assessment and care planning tool that was patients centred and individualised, and had to be completed with patients. This was not yet rolled out to all patients.

Patients had signed their care plans to confirm their agreement, or it was recorded that they did not want a copy.

There were weekly community meeting where patients raised their concerns, and requested activities.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that the quality and variety of food meets the needs of patients who may be in hospital for several years.
- The trust should ensure that staff can access training, to ensure they have the necessary knowledge of the Mental Health Act and the Mental Capacity Act.

Pennine Care NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Beckett Place	Tameside Mental Health Services
Bevan Place	Stockport Mental Health Services
Heathfield House	Heathfield House - Specialist Services Division
Hurst Place	Tameside Mental Health Services
Rhodes Place	Rhodes Place
Stansfield Place	Stansfield Place

Mental Health Act responsibilities

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

- Patients using the service were usually detained under the Mental Health Act.
- The trust had policies on the Mental Health Act and its implementation.
- Patients had their rights under the Mental Health Act explained to them.
- Patients had access to independent Mental Health Act advocates.
- We did not carry out a full review of the implementation of the Mental Health Act. However, the sample of Mental Health Act paperwork we reviewed was completed correctly. Consent to treatment for medication forms were completed and attached to medication charts.

Detailed findings

- The service had a Mental Health Act administration office that supported the correct implementation of the Act, carried out audits, and provided advice to staff.
- Training in the Mental Health Act was not part of the trust's mandatory training programme, and it was not clear how many staff had received training on the Mental Health Act. However, the staff we spoke with had an understanding of the Mental Health Act and its correct implementation.

Mental Capacity Act and Deprivation of Liberty Safeguards

There were no patients subject to the Deprivation of Liberty Safeguards. Patients using the service were usually detained under the Mental Health Act.

The trust had policies on the use of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Training in the Mental Capacity Act was not part of the trust's mandatory training programme, and it was not clear how many staff had received training on the Act. The staff we spoke with had an understanding of elements of the Act. For example, the principles of capacity assessment which included having the capacity to make seemingly unwise decisions, best interest, and least restrictive practice.

Patients had their capacity assessed with regards to whether they could make decisions. For example, about their physical health or future accommodation. Where patients had been deemed to lack the capacity to make a decision then action had been taken in their best interest.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

There were blind spots and potential ligature points in communal areas of some of the wards. Staff had completed environmental risk assessments for each of the wards. These identified and rated risks, which included ligature point risks, and how they were managed to keep patients safe. Patients' bedrooms had ligature free fittings.

The service complied with guidance on same-sex accommodation. Five of the wards were single sex. Stansfield Place was the only mixed-sex ward and this had separate sleeping and bathroom areas for men and women, and a female only lounge. Patients who were deemed to be at risk towards or from the opposite sex were admitted to a single gender ward.

Each ward had an equipped clinic room. All wards had resuscitation equipment and emergency medication. This was regularly checked and in date. Other emergency equipment such as ligature cutters was available and accessible to staff.

The wards did not have seclusion rooms.

The wards were mostly clean and well maintained. There were cleaning logs on all the wards. Infection control audits were carried out annually. The audit in January 2016 rated Heathfield House, Hurst Place and Bevan Place above the trust average of 96%. Beckett Place, Rhodes Place and Stansfield Place were below the trust average with Stansfield Place the lowest at 91%. The infection control concerns were rated – none were high risk, and there were action plans for all the points that were below the standard. These had been reviewed in April 2016 and most were completed or part of ongoing monitoring on the wards.

Staff on the stand alone units advised us that there had been problems with maintenance, as the buildings were owned by external companies. However, this had improved. For example Rhodes Place had had longstanding problems with the power and temperature of the showers, but these had now all been replaced.

An annual risk assessment of the wards had been carried out, which identified and resolved health and safety and cleanliness issues.

Each service had emergency alarms. Wards that were part of a bigger unit were part of a unit-wide response team. The standalone units (Heathfield House, Rhodes Place and Stansfield Place) had alarms, but these were only responded to by staff in the unit.

Safe staffing

Information provided by the trust showed that up to the end of January 2016, 113 nurses and healthcare assistants were employed by the long stay and rehabilitation service. The vacancy rate, which excluded staff on secondments, was lowest on Beckett Place and Rhodes Place at 0.7% and 3%. The other wards were above 11% with Heathfield House the highest at 20%. During the twelve months to the end of January 2016, seven staff had left the service from three of the wards.

Staff told us that there were periods when they were short staffed, but there were usually enough staff on duty. Bank and occasionally agency staff were used to cover gaps, and these tended to be staff who had worked in the unit before. The number of staff required varied depending on the needs of patients, and had improved over the last few months following successful recruitment. Ward managers were able to adjust staffing levels if this was required. Staff told us that activities, leave or one to ones with nursing staff may be cancelled because there were not enough staff but this was rare. If it did happen it was likely to be have been because another patient needed more support, or staff were supporting other wards.

The wards had adequate medical cover. This included an out of hours rota for junior doctors and consultant psychiatrists.

Staff had completed most of their mandatory training. Trust information showed that up to May 2016 the average mandatory training rate across the six long stay and rehabilitation wards was just over 93%. Beckett Place was lowest at 87%. The trust target for basic life support training was 95%. None of the wards had achieved this, but were between 86 and 90%, with the exception of Beckett Place at 65% (13 out of 20 staff). Staff told us that there would

Good

Are services safe?

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

always be someone on duty who was trained in basic life support, and that in the event of an emergency staff from wards in the same unit would also attend. The trust target for intermediate life support training, for qualified nurses, was set at 60%. Beckett Place had reached this at 60% (six out of 10 staff), and the other wards were between 75% and 89%.

Assessing and managing risk to patients and staff

Restraint was not regularly used on the long stay and rehabilitation wards. In the six months up to January 2016 there had been three incidents of restraint on Beckett Place and three on Rhodes Place. None of these were prone or face down restraints. Staff confirmed that although there could be violent incidents, most incidents on the wards involved verbal aggression, and that staff were skilled at de-escalating patients when they became agitated or distressed.

We looked at 22 care records. These all contained a risk assessment, and they had been updated when necessary. Pre-activity risk assessments were carried out by the occupational therapists.

The staff and managers we spoke with were aware of least restrictive practice, and were working towards this with their patients. The service had been reconfigured approximately 18 months ago, and since this time most staff confirmed that there had been a significant cultural change within the service. This included reviewing the use of restrictions, and balancing this against risks to patients and other people. Many staff believed this had improved, and was still progressing. There were some blanket restrictions, particularly with regards to access to outdoor space and smoking. This has been applied differently on all the wards. For example, of two wards with ground floor access to outdoor space one had open access during the day, the other had restricted access with timed smoking breaks. Senior managers told us this was because individual wards were making decisions based on their patient group.

Most patients were detained under the Mental Health Act. Beckett Place was within the secure unit, so had airlocks and key handling procedures. Although this placed restrictions on informal patients, we saw that they were aware of their rights with regards to leaving the ward, and that these were upheld. There were plans to change the entrance to the ward so that staff and patients did not have to go through secure procedures to get in and out of the ward.

Each ward checked the whereabouts of their patients at least hourly. The service followed the trust observation policy for the use of enhanced observation, and patients were on constant or intermittent observations depending on their level of risk. Each ward carried out routine checks of the environment each shift.

The wards did not use seclusion or long-term segregation. Rapid tranquilisation was rarely used. Staff were aware of the policy for monitoring a patient if rapid tranquillisation was used.

Staff had an understanding of safeguarding, and reported safeguarding concerns when necessary. Staff confirmed that most potential safeguarding concerns were when patients were intimidating towards other patients. There were examples where staff had identified concerns towards patients from people outside the service, and staff had taken appropriate action to protect the patient.

The service had processes for the management of medication, which included prescribing, ordering, storage, administration and disposal. There was pharmacy support to each of the wards, which included advice on the use of medication, and practical checking of medication and prescription charts. The trust had a procedure for the staggered self-administration of medication, with decreasing levels of supervision from nursing staff. One or two patients on each of the wards self-administered their own medication and were at different stages of the procedure.

Track record on safety

In the 12 months up to February 2016 there had been no serious incidents requiring investigation within the service.

All incidents were graded from one (least serious) to five (most serious). All incidents were listed in the monthly key themes report, and level four and five graded incidents were discussed at the monthly governance meeting attended by managers and leads within specialist services. Where further investigation or action was required, this was followed up at each meeting.

Good

Are services safe?

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Reporting incidents and learning from when things go wrong

Staff reported incidents using the trust's electronic incident reporting system. The staff member's line manager then reviewed incidents. The forms were automatically sent to other departments in the organisation depending on the type of incident. For example, potential safeguarding concerns would be sent to the safeguarding lead, and environmental concerns would be sent to the facilities department. The clinical governance lead reviewed all incidents, and ensured they were correctly assigned.

Managers attended a monthly governance meeting where both local incidents and those that had occurred elsewhere in the trust were discussed. Information and action to be taken was agreed and shared. Ward managers then discussed this in ward handovers and team meetings, and in individual supervision session if relevant.

Trust wide e-bulletins were sent to staff with key information about incidents, and changes that had been implemented as a result. For example, a patient had harmed themselves using curtains in another service. In response to this, changes had been made trust wide. Staff in this service were aware of the changes and why they had been made.

Staff told us that, on most occasions, following a serious incident they had been offered support and debriefing sessions, and that these had been helpful.

Duty of Candour

The incident forms included a section for staff to indicate if duty of candour was relevant, and to give a reason for this. The forms could not be closed without this section being completed. Staff told us that because of the low level of incidents and complaints, the threshold for the duty of candour was not often reached. However, they said that on a daily basis if, for example, a patient's leave was delayed or changed, they informed the patient and told them the reason why.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We looked at 22 care records.

All patients had had a detailed assessment carried out prior to and after admission. Physical healthcare checks had been carried out by the medical and nursing staff on admission. Physical healthcare checks were routinely carried out on all the wards by nursing staff. Patients were registered with a GP, and referred for specialist healthcare if necessary. Patients accessed ongoing physical healthcare.

The care records all included assessments and care plans. The service had started to implement 'My Shared Pathway' approximately two months before the inspection. This is a nationally recognised person centred care planning tool developed collaboratively by patients and professionals. Patients had a care programme approach meeting every six months, and the new care plans were being developed as part of this meeting. Consequently, not all patients had the new care plans as these were still being implemented. Many of the older care plans were not person centred and recovery orientated.

Patients' primary care records were stored in two paper files. One file was for medical records and the other for nursing and other professionals. The paper records were stored in locked offices. Care plans and reports were completed on a computer and printed off for the paper file. There wasn't an electronic record system, although the trust was in the process of implementing this. Electronic documents were stored in shared folders on the trusts computer system, with one folder for each patient on each ward. Access to each folder was limited to staff on the ward, and if a patient was transferred to a different ward the documents were securely emailed.

Best practice in treatment and care

Patients had access to physical healthcare, which included specialists when required. Patients were registered with a GP, and could access community or acute hospital services.

Patients had limited access to psychology. The service employed four psychologists (not all full time) across 11 long stay and rehabilitation, psychiatric intensive care, and forensic services. Two psychologists primarily worked on the long stay and rehabilitation wards. Each psychologist worked directly with a small number of patients, typically one or two on each ward. This included the use of research based therapies such as cognitive behavioural therapy, dialectical behaviour therapy, and motivational interviewing. The psychologists also worked with staff to promote a psychologically minded approach, and to support staff to enable them to work effectively with patients. This included group supervision and debriefing sessions. The psychologists also provided groups for patients and staff, such as mindfulness and meditation.

The clinical lead for psychological therapies in the Rehabilitation and High Support Directoratecarried out routine evaluations of the effectiveness of the different types of psychological supervision provided. These rated staff understanding and confidence after each session.

Skilled staff to deliver care

Occupational therapists and/or technical assistants worked on all the wards. The number of hours available on each ward varied, and this impacted on the work they were able to do with patients. Health care assistants provided support on some of the wards, but again this varied on the staffing levels and how busy the ward was at the time. Staff told us that part of their role, particularly with patients on the rehabilitation pathway, was to engage and motivate patients. This was time consuming, and could be difficult with the limited resource.

Each ward had access to psychology, with two across the six wards. Due to the resource, they provided a limited amount of direct patient therapy. They focused on providing support and advice to staff and promoted a psychologically-minded approach to care.

The trust had a supervision and appraisal structure. Most nurses and healthcare assistants told us that they had had supervision and an appraisal. Medical staff, occupational therapists and psychologists had regular supervision and appraisal.

Staff had completed training in the use of a My Shared Pathway, a collaborative care planning tool for care planning. Many of the staff were experienced at working in the service.

Multi-disciplinary and inter-agency team work

Each patient had a multidisciplinary meeting once a month to review their care in detail. This included ongoing care on the ward and discharge planning. This was attended by the consultant psychiatrist, nursing staff and other healthcare professionals depending on the ward. This included occupational therapy, pharmacy and psychology. All

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.

patients had a care programme approach (CPA) meeting within three months of admission, and then every six months. These were usually also attended by the patient's keyworker in the community. Patients attended these meetings, and families and carers were invited.

Each ward had a multidisciplinary team meeting every one or two days during the week where all patients were briefly discussed. Any particular concerns or events were discussed in detail and plans made. These were followed up on subsequent days. Nursing staff handed over to the incoming team between shifts. Key or important information was documented, and staff were aware of patients' needs and care plan.

Staff told us that there were good working relationships with the local GP services and acute hospitals. Patients were all registered with a local GP, and had routine health checks, and access to specialist care where necessary.

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

Most patients in the service were detained under the Mental Health Act. Training in the Mental Health Act was not mandatory, but staff told us they had had training, and they demonstrated an understanding of the Mental Health Act and its guiding principles. The service was focused on implementing least restrictive practice in accordance with the Mental Health Act code of practice. Staff told us that this was still a work in progress, but it had improved since the reconfiguration of services. For example, many patients now had more belongings in their rooms, as blanket restrictions about potentially harmful items were reviewed on an individual basis.

Patients had their rights under the Mental Health Act explained to them. This was reviewed each month. Patients knew their rights under the Mental Health Act. Patients had access to an independent mental health advocate. Details of this were on display, and most patients we spoke with had contacted the advocate or knew how to do so.

The sample of Mental Health Act records that we reviewed were completed correctly, and copies were filed in each patient's records. Consent to treatment forms were attached to medication charts.

Staff received administrative advice and support from a central Mental Health Act administration team. Staff told us they contacted the team when they needed advice on the Act. The Mental Health Act administration team carried out a monthly audit of the Act for each ward. This included when detentions were due to expire, when consent to treatment was due for review, and if rights had been read. This was reviewed routinely in supervision with qualified nurses for the patients they key worked.

Good practice in applying the Mental Capacity Act

The trust had policies on the Mental Capacity Act and the deprivation of liberty safeguards. The trust provided training on the Mental Capacity Act, but this was not mandatory. Most patients in the service were detained under the Mental Health Act. The use of Deprivation of Liberty Safeguards was rare, and there were no patients subject to them at the time of our inspection. Staff were able to describe when the safeguards may be used.

Training in the Mental Capacity Act was not mandatory in the trust. Nursing staff told us they had had training in the Mental Capacity Act, but not all of the nursing assistants. Staff we spoke with had an understanding of capacity and how this related to least restrictive practice. Medical staff led on capacity, and carried out capacity assessments of patients. Staff were able to cite some examples where the principles of the Mental Capacity Act had been used to make best interest decisions for individual patients. Examples of this related to decisions about physical health care and future accommodation. The views of families and carers were taken account of when decisions were made.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

The interactions we observed between staff and patients were friendly and respectful. Staff were responsive to patients' needs.

The patients we spoke with were mostly positive about the staff. They told us that staff were kind and polite, and usually knocked on their bedroom doors before entering.

Staff understood patients' needs, and spoke about them in a positive and recovery focused manner.

The involvement of people in the care that they receive

Patients were provided with information about the service before they arrived, and some patients had a pre-admission visit. There was information on display to orientate patients to the ward.

The service had recently started to implement a new care planning tool that actively involved patients in assessing their needs and planning their care. The care records where this had been implemented were person centred and individualised, compared to the other records which showed variable patient involvement. Some of the patients we spoke with were involved in their care planning and were able to describe in detail their plan of care, including medication and discharge. Patients had signed their care plans, or it was noted that they had not wanted to sign them.

Patients had access to an advocacy service. There were weekly community meetings on all the wards. Patients were able to raise concerns, or make suggestions about the ward. This included decision making about the activities they would like to take part in.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The service was set up as a step-down facility from forensic services, and to return patients who were in out of area placements back to the trust. The care pathways on each of the wards were for rehabilitation and discharge, and lasted from two to five years. Many of the people who were in out of area placements had completed the pathway, or were close to doing so, and had moved on. Consequently, the service had admitted some patients from other parts of the service. For example, from acute wards if patients had a lot of readmissions.

Most patients in the services were in a rehabilitation or discharge pathway. The length of pathway varied on each ward but the majority of patients were discharged within the timeframes of the care pathways. There were patients on each of the wards who had been there longer than five years. This was because they had complex or treatment-resistant illnesses. They were continuing to receive active treatment to facilitate their rehabilitation.

Bevan ward only admitted men who were over 50 with no upper age limit. At the time of our inspection the men's ages ranged from 60 to 80 years. The ward had had some patients who had received end or life care, or who had dementia. Patients with a primary diagnosis of dementia or who were severely physically unwell would not usually be admitted. However, as existing patients were older and on the ward for several years, if their health deteriorated during their admission there were discussions around their choices, best interest, and the care the ward was able to provide.

All admissions to the long stay and rehabilitation wards were planned. The average bed occupancy in the six months to the end of December 2015 was from 92% on Stansfield Place to 100% on Rhodes Place. As the length of stay was usually at least two years there was a relatively low turnover of patients. When patients went on leave their beds were not used for other patients. There was no waiting list for the service.

There were separate referral pathways for male and female patients. There was a separate monthly referral meeting for each of the pathways, chaired by a senior manager and the capacity and flow manager who managed all referrals. Referrals were discussed at the meeting and triaged by a consultant psychiatrist who determined which ward the person was most suitable for. Staff from the ward then assessed the patient, and considered not only whether they could meet the needs of the patient, but also whether there were likely to be any particular challenges with the current patient group. Staff told us they believed this process worked well.

The facilities promote recovery, comfort, dignity and confidentiality

There were communal lounges on each of the wards. There were areas where patients could meet with visitors, and patients were encouraged to visit relatives outside the unit when appropriate. There were payphones on the wards which were in corridors this meant that people conversations could be overheard. However, patients who had mobile phones could use these on the wards. There was access to outdoor space on each of the wards. Patients had personalised their bedrooms, and had access to televisions, music and other interests. This was risk assessed for each patient.

There were set mealtimes on each of the ward, and food was provided by different external organisations dependent on the location of the ward. A small number of patients on each ward made some of their own meals. Patients on some of the wards had persistently complained about the food. At Stansfield Place patients had submitted a petition about the quality of the food but told us that the quality of it had not improved. Food on Beckett Place and Hurst Place was provided on the same two-week menu cycle as the acute trust. As many patients had been in hospital for several years they were unhappy about the repetitiveness. Hurst Place had set up a food steering group and took photographs of food as evidence of when they were of poor quality/presentation. The complaints about food were being escalated by the trust.

Each ward had a kitchen or kitchenette where patients had access to drinks and snacks. Some wards locked the kitchen at night, but patients were still able to request drinks.

Activities were available on each of the wards. These were coordinated by an occupational therapist, technical assistant or activity coordinator. The activities available varied dependent on the patient group. They included ward-based activities such as cooking, breakfast groups, music or crafts, and outdoor activities such as unescorted leave, leisure groups such as walking, bowling or the

Are services responsive to people's needs?

Good

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

cinema. The availability of the activity programme was limited by the number of staff to carry it out. Healthcare assistants also supported or carried out activities, particularly out of hours including weekends.

Meeting the needs of all people who use the service

There were bedrooms available for disabled patients across the service, which included accessible bedrooms and bathroom and toilet facilities. Ward facilities were accessible by a lift, or were on the ground floor.

Interpreters were available, and information could be provided in alternative languages if necessary. Religious or spiritual support was accessible through the local community. Food was available to meet patients' religious or personal choices, for example for halal or vegetarian diets.

Listening to and learning from concerns and complaints

In the 12 months up to the end of April 2016 there had been two unrelated formal complaints across the six wards. The patients we spoke with said they knew how to make a complaint about the service. Information about the trust's complaints procedure was on display, and this included information about the Patient Advice and Liaison Service. There was a form patients could use if they wished to make a formal complaint. Staff were able to describe the complaints process.

There were weekly community meetings on all the wards. Patients could raise any concerns or complaints in this, and discuss what activities they wanted to engage in, or make suggestions about the ward. We saw a "you said, we did" board on the wards. For example, on Bevan ward patients had complained about a lack of activities, so new ones had been implemented. Staff told us that they did not receive many complaints, but if patients raised issues they would be discussed with the patient and in team meetings. There were ongoing complaints about food on some of the wards. These were being addressed, and patients and staff were having discussions with the organisation that provided the food.

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

Vision and values

The trust stated that its vision was "to deliver the best care to patients, people and families in our local communities by working effectively with partners, to help people to live well." In order to implement this it had ten principles of care which included safe and effective services, meaningful and individualised care, and engaging and valuing people. The staff we spoke with were not able to cite all these specifically, but were positive about patients and how they might move forward. Some staff told us that there had been a cultural change amongst staff towards being patient focused, and balancing safety and restrictions.

Good governance

There were arrangements in place for monitoring the effectiveness of the service. Managers attended the specialist services' monthly governance and quality meeting that included all services within the rehabilitation and high support directorate. Information from each of the wards was reviewed at this meeting which included incidents and improvements, clinical issues such as physical health, national initiatives, and complaints. Information from other sources fed into the meeting, such as the health and safety meeting and the matron's report. The specialist services monthly governance and quality meeting fed into the trust-wide governance meetings. Similarly, clinical issues and significant incidents or initiatives that had happened elsewhere in the trust fed into the specialist services meeting. How they applied to local services was then discussed, actioned, and followed up.

Information collected by the trust was compiled into a monthly key themes report that was reviewed at the monthly governance meeting. This included a range of information such as numbers and details of incidents, complaints and medication incidents. Themes were discussed, and any necessary actions assigned to staff, which were followed up at subsequent meetings. A health and safety report was produced each month that monitored issues about the environment and infection control.

Information about incidents was shared with staff across the trust. Feedback and actions from the governance meeting were shared at ward meetings, and through ward handovers and individually in supervision. Managers also emailed staff to draw their attention to changes, updates, and learning from incidents.

The trust gathered information about staffing which included resources, supervision and training. This was monitored corporately, and ward managers accessed this information so that they were able to take any action required at a local level. Managers attended a monthly budget meeting. This was to review the ward's finances, but also monitored and reviewed actions for staff levels which included vacancies, sickness and absence, and bank and agency usage.

Ward managers were able to submit items to be added to the risk register. These were discussed through the clinical governance meeting, and added if this was agreed. The risk register was filtered so that managers could only see the risks relevant to the service they worked in. The corporate risk register included items that were trust or service wide so were applicable to the long stay and rehabilitation service, but there were none that just applied to that part of the service.

Leadership, morale and staff engagement

In the 12 months up to the end of January 2016, the sickness rates on Beckett Place were below the trust average at 4%, but the remainder were above 9%, with the hightest being Hurst Place at 13% on Hurst Place.

Most of the staff we spoke with were positive about the service, their teams and the support they received from managers. Most said they felt able to speak out if they had concerns. Staff told us there had been difficult periods, but they were positive about the changes that had been made within the service, and felt that this had led to improvements for staff and patients.

Commitment to quality improvement and innovation

The service was not part of any national quality improvement programmes, and there were no research projects on any of the wards.

The implementation of 'My Shared Pathway' was a commissioner-set target for the forensic service, but not for the long stay and rehabilitation service. However, the trust had decided to implement 'My Shared Pathway' in the service in order to improve the quality, recovery focus and person-centeredness of care and care planning.