Good

Tees, Esk & Wear Valleys NHS Foundation Trust

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

Quality Report

West Park Hospital
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Cross Lane Hospital	RX3LK	Danby Esk	YO12 6DN
Friarage Hospital Mental Health Unit	RX3XX	Ward 15	DL6 1JG
Roseberry Park	RX33A	Bransdale Bedale Bilsdale Overdale Stocksdale	TS4 3BW
West Park Hospital	RX3MM	Cedar Elm	DL2 2TS

Summary of findings

		Maple	
Lanchester Road Hospital	RX3CL	Tunstall Farnham	DH1 5RD
The Briary Unit	RX3YE	Cedar	HG2 7SX
Sandwell Park	RX3NH	Lincoln	TS24 8LL

This report describes our judgement of the quality of care provided within this core service by Tees, Esk & Wear Valleys 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 Tees, Esk & Wear Valleys NHS Foundation Trust and these are brought together to inform our overall judgement of Tees, Esk & Wear Valleys 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 Acute wards for adults of working age and psychiatric intensive care units	Good 
Are Acute wards for adults of working age and psychiatric intensive care units safe?	Requires Improvement 
Are Acute wards for adults of working age and psychiatric intensive care units effective?	Good 
Are Acute wards for adults of working age and psychiatric intensive care units caring?	Good 
Are Acute wards for adults of working age and psychiatric intensive care units responsive?	Good 
Are Acute wards for adults of working age and psychiatric intensive care units 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

Cedar at the Briary Unit and Ward 15 were located in older medical wards on acute hospital sites and therefore had environmental limitations. Therefore privacy and dignity were not always respected due to shared single sex bed bays and environments posed ligature risks. On Ward 15 there were a number of environmental concerns identified with the seclusion room and recording of seclusion episodes.

Across the acute and PICU wards intervention plans were not in place for some patients after risk had been identified. Systems in place to audit the content of care plans were not effective in picking up these shortfalls.

There were varied and inconsistent blanket restrictions in place across the acute and PICU wards.

Patients' physical healthcare was not assessed before physical restraint was used.

Patients had a comprehensive assessment of their needs upon admission and care plans were recovery focused and based on best practice. Care plans were reviewed on a regular basis at multi-disciplinary team meetings. However there was a lack of evidence of patient involvement in formulating care plans.

The acute and PICU wards used a number of measures to monitor the effectiveness of the service provided.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice.

The acute and PICU wards had good systems in place to ensure that the responsibilities of the Mental Health Act 1983 (MHA) and the Mental Capacity Act (MCA) were being followed. However we found a number of shortfalls which we have asked the trust to address.

Patients were treated with compassion and empathy. Feedback received from patients was positive about their experiences of the care and treatment provided by the staff. The patients we spoke with were complimentary about staff attitude and engagement.

Patients using the service had opportunities to be involved in decisions about their care. Patients told us that their care plans were discussed with them, they were encouraged to attend their review meetings and they had a copy of their plan if they wished.

All admissions had clear reason, a development of a clear formulation and a clear plan as to goals to be achieved to facilitate discharge when clinically appropriate.

A clear PICU admission process was in place to ensure this was appropriate, timely arrangements were in place to transfer patients back to the acute wards when clinically necessary. Systems enabled transfer of patients without delay.

There were good working links with the community mental health teams (CMHT) to facilitate discharge from the wards. Regular bed management meetings occurred with representatives from the CMHT to consider discharge planning.

Patients were actively encouraged to participate in a wide range of activities. Patients' diversity and human rights were respected. Complaints and concerns were taken seriously and responded to in a timely way and listened to.

The trust's vision and strategies for the service were evident and most staff considered they understood the vision and direction of the trust.

The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust.

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their dedication to providing quality patient care.

Most of the acute and PICU wards were members of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation scheme called AIMS and were accredited with excellence.

Summary of findings

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

Are services safe?

Requires Improvement

We rated the acute and PICU wards as requires improvement because:

Cedar at the Briary Unit and Ward 15 were located in older medical wards on acute hospital sites and therefore had environmental limitations.

Privacy and dignity were not always respected due to shared single sex bed bays. At Cedar and Ward 15 there were thin curtains around each bed bay which did not minimise light or sound effectively. At Ward 15 the bay bedroom windows did not provide reflective glass to provide privacy from the outside where other acute hospital wards and offices were located. Curtains were in place across the windows however these were thin and did not always obscure the view into the ward bedrooms.

On Ward 15 there were a number of environmental concerns identified with the seclusion room and recording of seclusion episodes.

The older ward environments posed ligature risks such as non anti-ligature beds on Cedar at the Briary Unit and Ward 15 and suspended ceilings on Ward 15.

On Cedar on Briary Unit there was a lack of clear guidance to help staff minimise or mitigate the risks to patients of existing ligature points.

Intervention plans were not in place for some patients after risk had been identified. Systems in place to audit the content of care plans were not effective in picking up these shortfalls.

There were varied and inconsistent blanket restrictions in place which were not based on individual risk e.g. restrictions for cigarette lighters, razors, mobile phones, mobile phone chargers and internet access.

Patients' physical healthcare was not assessed before physical restraint was used. Functional assessment was not being carried out and was not recorded on any of the patient records that we looked at.

Are services effective?

Good

We rated the acute and PICU wards as good because:

Summary of findings

Patients had a comprehensive assessment of their needs upon admission which included consideration of clinical needs, mental health, physical health and wellbeing, nutrition and hydration needs.

Care plans were recovery focused and helped patients receive support to address the symptoms of mental disorders. Care plans included relapse prevention and crisis planning.

Patient needs and care plans were reviewed on a regular basis at multi-disciplinary team meetings and at allocated Care Programme Approach (CPA) meetings.

However we found there was a lack of evidence in the electronic notes system called PARIS of patient involvement in formulating care plans in the majority of care plans that we reviewed.

People's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

The acute and PICU wards used a number of measures to monitor the effectiveness of the service provided.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice.

Patients received multi-disciplinary input, were encouraged to take ownership of MDT meetings and encourage to participate fully. The acute and PICU wards had good systems in place to ensure that the responsibilities of the Mental Health Act 1983 (MHA) were being followed. However we found a number of shortfalls which we have asked the trust to address.

We found evidence that the Responsible Clinician (RC) had assessed and recorded patients' capacity to consent to medication, as well as documenting their discussion about medication and its purpose and effects.

Are services caring?

Good

We rated the acute and PICU wards as good because:

Patients were treated with compassion and empathy. Feedback received from patients was positive about their experiences of the care and treatment provided by the staff. The patients we spoke with were complimentary about staff attitude and engagement. Patients shared a number of examples of how they felt well supported.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care.

Summary of findings

Patients using the service had opportunities to be involved in decisions about their care. Patients told us that their care plans were discussed with them, they were encouraged to attend their review meetings and they had a copy of their plan if they wished.

Community meetings were held regularly on the wards.

Patients had regular access to advocacy.

Carers were actively involved in patient's care.

On some of the acute wards there was a pilot assessment in place to capture patient views called 'All About Me' this was in use at some wards. This had not been rolled out through all of the acute and PICU wards and where this was absent there was nothing in place for capturing patient's views, hopes, goals and incorporating them into the care plans.

The care plan documents across the trust were found in the electronic patient notes (PARIS) system and from reviewing this it was difficult to see how the involvement of the individual was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in PARIS.

Are services responsive to people's needs?

Good

We rated the acute and PICU wards as good because:

All admissions had clear reason, a development of a clear formulation and a clear plan as to goals to be achieved to facilitate discharge when clinically appropriate.

A clear PICU admission process was in place to ensure this was appropriate, timely and arrangements were in place to transfer patients back to the acute wards when clinically necessary. Systems enabled transfer of patients without delay.

Discharge discussions took place at daily report out meetings with expected discharge dates set and reviewed regularly. We could not however see that discharge plans had been put into place for patients on the acute wards until discharge was imminent.

There were good working links with the community mental health teams (CMHT) to facilitate discharge from the wards. Regular bed management meetings occurred with representatives from the CMHT to consider discharge planning.

Patients were actively encouraged to participate in a wide range of activities.

Patients' diversity and human rights were respected.

Summary of findings

Complaints and concerns were taken seriously and responded to in a timely way and listened to.

Are services well-led?

Good

We rated the acute and PICU wards as good because:

The trust's vision and strategies for the service were evident and most staff considered they understood the vision and direction of the trust.

The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust.

There were regular meetings for managers to consider issues of quality, safety and standards.

Data was collected regularly on performance. Each acute ward compiled performance data that recorded their performance against a range of indicators and was reported at divisional monthly performance clinics attended by ward managers.

There was opportunity for staff to submit organisation/team risks to the trust risk register. Not all ward managers however were aware that they could contribute risks to a local risk register specific to their service risks.

There were systems in place to gather feedback form patients on an on going basis through Patient Experience Trackers (PET) which was a tablet computer based on each ward which collected real time feedback from staff, patients and carers. Performance against the results of the PET were analysed on a monthly basis and actions were put into place to ensure that shortfalls were improved upon. Feedback we received from the majority of staff was that the questions asked of patients were not clear and did not capture useful data or lead to useful changes.

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their dedication to providing quality patient care.

Most of the acute and PICU wards were members of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation scheme called AIMS.

Summary of findings

Background to the service

Tees, Esk and Wear Valleys NHS Foundation Trust provides inpatient services for men and women aged 18 years and over with mental health conditions. These services are provided for people who are admitted informally and patients compulsorily detained under the Mental Health Act. This reports looks at all of the acute inpatient wards and psychiatric intensive care units (PICU) provided by the trust.

These services are based across 13 acute inpatient wards and two PICUs over seven hospital locations;

The Briary Unit in Harrogate District Hospital:

- Cedar Ward is an 18 bed mixed gender acute inpatient ward

Cross Lane Hospital in Scarborough:

- Danby is a 13 bed male acute inpatient ward
- Esk is a 13 bed female acute inpatient ward

Friarage Hospital Mental Health Unit in Northallerton:

- Ward 15 is a 13 bed mixed gender acute inpatient ward

Lanchester Road Hospital in Durham:

- Farham is a 20 bed male acute inpatient ward
- Tunstall is a 20 bed female acute inpatient ward

Roseberry Park in Middlesbrough:

- Bedale is a 10 bed mixed gender PICU
- Bilsdale is a 14 bed male acute inpatient ward
- Bransdale is a 14 bed female acute inpatient ward
- Overdale is an 18 bed female acute inpatient ward
- Stocksdale is an 18 bed male acute inpatient ward

Sandwell Park in Hartlepool:

- Lincoln is a 20 bed mixed gender acute inpatient ward

West Park Hospital in Darlington

- Cedar is a 10 bed mixed gender PICU
- Elm is a 20 bed mixed gender acute inpatient ward
- Maple is a 20 bed mixed gender acute inpatient ward

Tees, Esk and Wear Valleys NHS Foundation Trust have been inspected on a number of occasions since registration. The acute in-patient services have not previously been inspected by the CQC at Roseberry Park.

We have also carried out regular Mental Health Act (MHA) monitoring visits to the acute wards and PICUs at all locations with all of the wards having had a MHA monitoring visit within the last 18 months of this inspection. Where we found issues relating to the MHA on these monitoring visits, the trust have provided an action statement telling us how they would adhere to the MHA and MHA Code of Practice. We checked to see if these improvements had been made during our inspection.

Our inspection team

Our inspection team was led by:

Chair: David Bradley, Chief Executive South West London and St Georges NHS Foundation Trust.

Team Leader: Patti Boden, Inspection Manager, Care Quality Commission

Head of Inspection: Jenny Wilkes, Head of Hospital Inspection, Care Quality Commission

The team visiting acute inpatient and PICU services included an allied mental health Professional (AMHP), a consultant psychiatrist, an expert by experience, a CQC inspection manager, a mental health act reviewer, a pharmacist, a ward manager and four mental health nurses.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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?

Prior to the inspection we reviewed a range of information we held about acute inpatient wards and PICUs and asked other organisations to share what they knew.

We carried out an announced visit on 20, 21, 27, 28, 29 and 30 January 2015 all of the acute inpatient and PICU wards listed above.

During the inspection visit, the inspection team;

- spoke with 43 patients,
- spoke with the managers for each of the 16 wards visited,
- spoke with 105 other staff members including consultant psychiatrists, junior doctors, psychologists, modern matrons, qualified nurses, health care assistants, speech and language specialists, occupational therapists, gym instructors, housing officers, pharmacists and ancillary staff,
- attended and observed multi-disciplinary, formulation and daily report out meetings,
- looked at 41 treatment records of people,
- carried out a specific check of the medication management,
- looked at a range of policies, procedures and other documents relating to the service.

What people who use the provider's services say

We received 127 comments cards from the acute and PICU wards. We spoke with 43 patients during the inspection.

Overall, patients we spoke with told us that staff treated them with dignity. Patients said they could approach staff with any issues they had and staff treated them with respect and care.

Overall people were happy with the service they were receiving and the support which was provided to them.

Patients were complimentary about staff and told us the staff were kind, caring and treated them with dignity. On the wards, we saw patients were being supported by kind and attentive staff. We observed that staff showed patience and gave encouragement when supporting patients.

Relatives and carers told us staff were responsive to their needs and treated them with dignity and respect.

Patients who used the services told us that they felt safe.

People using the services were positive about the staff and the care they received and felt involved.

Good practice

As part of the TEWV Quality improvement system the acute and PICU wards followed the principles of the 'Virginia Mason Production System' an evidence based way of working from Seattle. Part of this included a

Summary of findings

meeting on each ward called a 'report out'. This was attended by staff in the morning on a daily basis where each patient was discussed using a visual display board looking at current care and risk factors and tasks were set for staff for the day. We attended a 'report out' meeting on each hospital site and found these to be an effective system for ensuring care was patient focussed, therapeutic, informed by risk and formulated with discharge as a focus.

The PICU pathway was particularly well managed at Roseberry Park where four acute wards and one PICU were located. There was admission flow chart in place based around the principles of the 'PICU pyramid' which was a care planning approach to engage patient in the management of their behaviours to prevent PICU admission. When a PICU admission was required as a last resort these care plans were in place and ready to be implemented. The plans incorporated measures to proactively encourage patients to move back to the acute ward even before transfer to the PICU had taken place.

We saw areas of good practice being used on the wards such as Trauma Clinical Link Pathway (CLiP) which was a tool being used to assess trauma in patients lives and incorporate this into recovery. There was also 'grounding' toolkits available for wards to use which was box of visual aids used to express past traumas.

At Roseberry Park there were excellent dedicated facilities for activities and occupational therapies called 'Activity Street' incorporating pottery art, cookery, yoga, use of a pool table and musical instruments. There was a gym with a gym instructor available.

The trust had been named as the provider of the year 2014 by the Royal College of Psychiatrists based on widespread participation in quality improvement programmes. This showed a dedication to quality improvement across the majority of the acute and PICU wards.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider must ensure that current risks have an associated intervention plan which clearly outlines measures to manage the risk with the input of the patient.

The provider must ensure that all staff on Ward 15 are given clear guidance on the management of ligature risks and current risks posed by patients and make the appropriate adjustment to observation levels.

The provider must ensure an effective quality monitoring system is in place for joint working with partner NHS trusts where services are provided from.

The provider should ensure that privacy and dignity is maximised in the bed bays of ward 15 and Cedar at the Briary Unit.

The provider should ensure that the recording of any episodes of seclusion are documented separately from daily notes and are comprehensive.

The provider should review blanket restrictions across all acute and PICU to ensure that the risks are assessed on an individual basis.

The provider should ensure that patients are involved in writing care plans and this is evidenced in PARIS.

The provider should ensure systems are in place to capture the shortfalls in the Mental Health Act and Mental Capacity Act as identified by the MHA reviewers at Ward 15, Cedar at the Briary Unit, Overdale and Stockdale.

The provider should ensure that the patient survey on the Patient Experience Tracker (PET) can be understood and provide meaningful data.

The provider should ensure that ward managers are aware of local risk registers and how to contribute to them.

Tees, Esk & Wear Valleys 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
Danby Esk	Cross Lane Hospital
Ward 15	Friarage Hospital Mental Health Unit
Bransdale Bedale Bilsdale Overdale Stocksdale	Roseberry Park
Cedar Elm Maple	West Park Hospital
Tunstall Farnham	Lanchester Road Hospital
Cedar	The Briary Unit
Lincoln	Sandwell Park

Detailed findings

Mental Health Act responsibilities

Adherence to the MHA and the MHA Code of Practice

Patients received multi-disciplinary team input and were encouraged to take ownership of MDT meetings and encourage to participate fully. The acute and PICU wards had good systems in place to ensure that the responsibilities of the Mental Health Act 1983 (MHA) were being followed. However we found a number of shortfalls which we have asked the trust to address.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found evidence that the responsible clinician (RC) had assessed and recorded their capacity to consent to medication, as well as documenting their discussion about medication and its purpose and effects.

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

Summary of findings

We rated the acute and PICU wards as requires improvement because:

Cedar at the Briary Unit and Ward 15 were located in older medical wards on acute hospital sites and therefore had environmental limitations.

Privacy and dignity were not always respected due to shared single sex bed bays. At Cedar and Ward 15 there were thin curtains around each bed bay which did not minimise light or sound effectively. At Ward 15 the bay bedroom windows did not provide reflective glass to provide privacy from the outside where other acute hospital wards and offices were located. Curtains were in place across the windows however these were thin and did not always obscure the view into the ward bedrooms.

On Ward 15 there were a number of environmental concerns identified with the seclusion room and recording of seclusion episodes.

The older ward environments posed ligature risks such as non anti-ligature beds on Cedar at the Briary Unit and Ward 15 and suspended ceilings on Ward 15.

On Cedar on Briary Unit there was a lack of clear guidance to help staff minimise or mitigate the risks to patients of existing ligature points.

Intervention plans were not in place for some patients after risk had been identified and systems in place to audit the content of care plans were not effective in picking up these shortfalls.

There were varied and inconsistent blanket restrictions in place which were not based on individual risk e.g. for cigarette lighters, razors, mobile phones, mobile phone chargers and internet access.

Patients' physical healthcare was not assessed before physical restraint was used. Functional assessment was not being carried out on any of the patient whose records that we looked at.

Our findings

Safe and clean ward environment

With the exception of Cedar at the Briary Unit and Ward 15, all of the acute and PICU inpatient wards were modern, purpose built environments. Cedar at the Briary Unit and Ward 15 were located in older medical wards on acute hospital sites and therefore had environmental limitations. There had been considerable investment to modernise the two ward environments but they were not fit for purpose. We were informed that there were plans in place for Cedar to be relocated to a new purpose built site which had been identified by the trust in Harrogate. There were also plans in place for Ward 15 to be relocated however new premises had not yet been identified by the trust. The trust were aware of these issues which were identified on the corporate risk register. Both ward managers of Cedar at the Briary Unit and Ward 15 described difficulties ensuring environments were appropriately maintained due to the estates departments being attached to the acute hospitals and not under the provider.

All of the wards were clean, well maintained and the corridors were clear and clutter free. We reviewed cleaning schedules which showed that wards were cleaned regularly and spoke with domestic staff who were present on the wards throughout the inspection. Wards conducted audits of cleanliness and infection control and prevention to ensure that people who used the service and staff were protected against the risks of infection. We reviewed three ward's infection control audits and found that any actions that needed to be implemented were followed up in a timely manner.

Emergency equipment, including automated external defibrillators and oxygen, was in place. It was checked weekly in line with the trust's policy to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked weekly. Staff had had training in life support techniques called Resus training.

Male and female sleeping areas were separate on all the acute and PICU wards we visited. Most were single rooms

Requires improvement

Are services safe?

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

with en-suite facilities. Where rooms did not have en-suite facilities there was access to a separate male or female-only bathroom and toilet facilities. There were separate female-only lounges on all of the mixed wards which provided a safe space for women who preferred a women-only environment.

However on Ward 15 and Cedar Ward at the Briary Unit there were single sex shared bed bays with shared bathroom facilities. This was not ideal to ensure patient's privacy and dignity. The ward managers recognised that the bay environments did not always provide privacy. Specific issues around the bed bays included;

- At Cedar and Ward 15 there were thin curtains around each bed bay which did not minimise light or sound. Patients and staff raised this as a concern.
- At Ward 15 the bay bedroom windows did not provide reflective glass to provide privacy from the outside where other acute hospital wards and offices were located. Curtains were in place across the windows however these were thin and did not always obscure the view into the ward bedrooms.

Some of the mixed gender wards had 'swing beds' which allowed gender segregated areas to be opened up if there were more males or females admitted. These were managed well and allowed an effective system for managing admission.

Ward layouts allowed staff to observe most parts of the ward. Mirrors had been installed in some wards where observation was restricted. We were informed that when patient required more frequent observation the ward observational policy guided staff about increased levels of observation to be used. CCTV was in use in most wards in the communal areas only. However it was not used to observe patients and staff but as a means to provide evidence for any clinical incidents that took place.

Any environmental risk had been identified by each ward manager through the environmental risk assessment survey. There was a plan in place to manage each risk which included adhering to trust policies, procedures and standard processes, individual risk assessments, engagement/observation levels and risk management plans. Where the removal of a risk was required there was a plan in place with a timeline for work to be undertaken in most wards.

However on Ward 15 there were a number of concerns identified with the seclusion room. These included:

- Blind spots identified where patients could remain out of sight of the observing staff. We were informed that a mirror had been requested to be put in place to the South Tees Hospitals NHS Foundation Trust estates department but this had not been actioned. We were shown on a request form that had been approved by the quality assurance group (QUAG) and that this risk had been escalated to the service risk register. The trust had taken the appropriate action to identify and escalate this environmental concern however this had not been responded to by the estates department.
- There was no two-way communication system therefore a patient would have to shout to speak to staff. There was however no evidence that any action had been taken to request a two way communication system.
- There were ligature risks on the door frame and in the shower head in the bathroom. There was an environmental risk management plan to manage these risks however there was no action to remove these.
- We were unable to find a recording system which contained a separate, step by step account of the seclusion procedure. Records of seclusion were integrated into the daily notes and entries were not complete for the most recent record of seclusion.

There were other environmental issues:

- At Cedar at the Briary Unit the temperatures on the ward were variable with some rooms being very warm and others were very cold. The ward manager told us that this had been escalated to estates however this was a consequence of the heating system in the hospital
- The outside space at Ward 15 was located on the ground floor off the ward, which was on the first floor. This could only be accessed by passing through the corridor where the seclusion and the de-escalation suite was located. The gates to the garden area were not locked and could be easily climbed. We saw that there had been a number of incidents were patients had gone away without leave (AWOL) from the garden area. Although patients were always supervised by staff we could see no action that had been taken to mitigate this risk.
- At Ward 15 and Cedar at the Briary Unit, due to the outside space being located off the ward there were restrictions in place that only allowed patients to go

outside with staff at set time periods throughout the day, mainly for smoking breaks. On Ward 15 there was no scheduled access to outside space after 7:15pm until 9:00am the next day for detained patients due to staff being unable to supervise access to the outside space.

We identified ligature risks on some of the wards that we had visited. In the purpose built units these were kept to a minimum due to the design and layout of the ward environments. The older ward environments posed further ligature risks such as:

- Non anti-ligature beds on Cedar at the Briary Unit and Ward 15. There had previously been a suicide in the trust using this type of bed that could be used to ligature. At Ward 15 new fixed box beds had been ordered and were due to be delivered the week following the inspection.
- At Ward 15 there were suspended ceilings in place. These had been identified as a ligature risk by the ward manager on the environmental survey dated March 2014. These ceilings housed piping and electrical work and could be accessed by patients. We saw that there had been an incident reported on the ward where a patient had entered the ceiling in a bedroom and fallen into to the dining area.

Environmental risk assessments had been carried out on all acute and PICU wards and were up to date. The ligature risk assessments had identified ligature risks on all wards. The trust had taken action to address some of the ligature risks identified. There were plans in place to conduct a larger programme of work which would address many of the existing risks.

However on Cedar on Briary Unit there was a lack of clear guidance to help staff minimise or mitigate the risks to patients of existing ligature points. Staff we spoke with, including bank and agency staff, were unaware how the existing ligature risks were being managed. Staff were not able to explain the different approaches to managing risks, for example in the bathrooms on Cedar on Briary Unit. There was no record of what or how decisions about ligature risk management in the ward environment had been made.

Safe staffing

We were provided with the individual staffing levels for all the acute inpatient and PICU wards before the inspection. The acute and PICU wards displayed the expected and actual staffing levels on each ward entrance. The actual staffing levels matched or exceeded the expected staffing levels. Ward managers told us they had the authority to adjust staffing levels to the needs of the patients in their care, for example if patients were in seclusion or required higher levels of observation.

Cedar Ward at the Briary Unit had higher levels of staff vacancies and sickness compared to the other acute wards. These issues were managed through the use of overtime, bank and agency staff. Whilst staffing levels were kept safe, the higher use of bank and agency staff was an area of concern raised by some patients who told us that inconsistent members of staff made it difficult to forge relationships and trust the staff members. Cedar Ward at the Briary Unit had an active recruitment plan in place to fill their vacant posts although the ward manager expressed that recruiting to the ward was difficult due to the old environment and the location of the ward.

At night time minimum staffing levels across the acute wards consisted of one qualified and two unqualified staff. To ensure that enough staff were available to assist in the event of a incident such as seclusion or restraint (where a minimum of three staff would be required), many wards had an arrangement in place with neighbouring wards to provide an alarm call response to assist. This system was in place in most areas however at Lincoln ward (20 beds), Cedar Ward at the Briary Unit (18 beds) and Ward 15 (13 beds) there was only one other ward able to provide an emergency response to alarm calls at night. There were however adequate systems in place to risk assess any situations that may have required more staff to be in place and the ward manager told us that they were able to access additional staff.

Assessing and managing risk to patients and staff

We spoke with patients on all the acute wards we visited. The majority of people told us they felt safe.

During our visit we looked at 41 people's care planning documentation. Individual risk assessments called FACE had been conducted for all patients on the wards. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments that we reviewed took account of patients'

Requires improvement

Are services safe?

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

previous history, as well as their current mental state. FACE risk assessments were carried out by staff during patients' initial assessment and were reviewed or updated during care review meetings or if patients' needs changed.

With each associated risk identified to individual patient there was an 'intervention plan' in place that guided staff and patients on how risk would be managed. This was reviewed on an on going basis. In most wards these were in place, specific to the needs and risks of the individual and were kept up to date.

However we identified that some intervention plans were not in place for some patients after risk had been identified:

- On Ward 15 we found risk associated with patients around self harm, suicide risk and risk posed due to an eating disorder. There were no intervention plans in place related to these risks for these patients. This was especially concerning as one person was at risk of ligature on the ward which had been confirmed by a history of suicidal behaviours, recent incidents where the person had been found with a ligature around their neck including one incident two weeks prior our visit. The combination of the environment with multiple ligature points and the increased use of bank and agency staff on the ward who require access to information about risk made this a significant concern.
- On Elm we found that a patient had been identified as being at risk of self neglect, however there was no intervention plans in place to manage this.

We were told that there was a system in place to review the content of care plans by the modern matron for each area. This looked at a sample of records on a monthly basis. We requested information about this audit and found that the system was not effective in identifying the shortfalls in the care plans in these areas.

Staff had received training in safeguarding vulnerable adults and children and all staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trust safeguarding policy and could name the safeguarding lead. They knew who to inform if they had safeguarding concerns. Safeguarding was discussed at ward team meetings and it was a standing item on the agenda for meetings. Safeguarding discussions with staff also took place during supervision, to ensure staff had sufficient awareness and understanding of the safeguarding procedures.

Appropriate arrangements were in place for the management of medicines on all of the acute and PICU wards. We reviewed the medicine administration records for several patients on each ward we visited. Nursing staff carried out regular checks on medicine prescription and administration records to make sure that these were accurate and fully completed and to identify any medicine omissions. The medicines management team reconciled all patients' medicines on admission and assessed the suitability of patients' own medicines for use where necessary.

Pharmacists were fully integrated into MDTs for inpatient services to support and ensure best outcomes from the use of medicines. Pharmacists attended the ward daily Report Out where clinical teams discussed the on-going treatment of each patient, and actively contributed to the safe management of their medicines. Pharmacy staff carried out a full clinical check of all prescription and administration records daily, Monday to Friday and alerted clinical staff if patient safety monitoring checks were due or had been overlooked, or if a person's medication required a review. They monitored medicine omissions and ensured that these were investigated and reported via the Datix electronic incident reporting system where appropriate.

The use of high dose antipsychotic treatment was closely monitored and pharmacists alerted the clinical team when monitoring tests or medication reviews were due to reduce the risk of any adverse effects. Nursing staff told us that they had easy access to medicines information and that a pharmacist would discuss medicines with individual patients if this was requested.

Patients and their carers were provided with information about their medicines and a pharmacist was available to support this. The clinic rooms used to dispense medication was clean and tidy. Medicines were stored safely and pharmacy staff audited medicines security and the management of controlled drugs.

The wards had a good system to ensure risks were reviewed or undertaken prior to a detained patient commencing leave from the ward.

Requires improvement

Are services safe?

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

Staff were aware of their responsibilities to undertake searches and checks on patients balancing the need to promote patients' dignity and safety. Staff told us they felt safe on the wards and supported by colleagues to maintain appropriate relational and actual security arrangements.

Blanket restrictions were minimised in most of the acute and PICU wards and positive risk taking was in place. We saw that individual therapeutic risk taking assessment had been undertaken to consider the patients individual needs balanced against risk in areas such as taking leave from the wards. However there was inconsistency across the acute wards as we found some blanket restriction in places at some wards on not in others:

- At Tunstall ward there was signage displayed that visitors were not allowed in patient bedrooms and no access was allowed to outside space during meal times. These signs were however removed during the inspection.
- At the acute wards at Roseberry Park and Lanchester Road Hospital there were varied and inconsistent blanket restrictions in place which were not based on individual risk e.g. for cigarette lighters, razors, mobile phones, mobile phone chargers and internet access.
- At Lincoln ward there were no blanket restrictions in place as risk was assessed on an individual basis.

There was a programme in place to reduce the amount of physical restraints throughout the trust with a focus on verbal de-escalation through the principle of the management of violence and aggression (MOVA). There was MOVA training available and all staff that would use restraint were trained.

There was no evidence that an physical health assessment was being carried out on any of the patient records that we looked at in relation to physical restraint. There was no consideration of patients physical healthcare being assessed before being restrained that could be found in patients care plans.

There was a policy in place around admitting young people (age 16-17) when necessary to an acute ward. There had been four instances where 17 year olds had been admitted to acute wards in 2014, each of which was individually risk assessed and assigned to the designated acute wards identified for this admission type. There had been no admissions of under 16's on to the acute wards.

Reporting incidents and learning from when things go wrong

Staff we spoke with on all acute wards knew how to recognise and report incidents on the trust's electronic incident recording system, Datix. All incidents were reviewed by the ward manager and forwarded to the trust's clinical governance team, who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.

Ward managers told us how they maintained an overview of all incidents reported on their wards. Incidents were investigated and some managers told us they were made aware of incidents that had occurred on other wards at weekly meetings of ward managers and the modern matron. We saw evidence that there was learning from incidents such as a new fence being installed at Danby due to a high number of patients going AWOL from the ward by climbing over the fence.

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.

Summary of findings

We rated the acute and PICU wards as good because:

Patients had a comprehensive assessment of their needs upon admission which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.

Care plans were recovery focused and helped patients receive support to address the symptoms of mental disorders. Care plans included relapse prevention and crisis planning.

Patient needs and care plans were reviewed on a regular basis at multi-disciplinary team meetings and at allocated Care Programme Approach (CPA) meetings.

However we found there was a lack of evidence in the electronic notes system called PARIS of patient involvement in formulating care plans in the majority of care plans that we reviewed.

Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

The acute and PICU wards used a number of measures to monitor the effectiveness of the service provided.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice.

Patients received multi-disciplinary team input and were encouraged to take ownership of MDT meetings and encourage to participate fully. The acute and PICU wards had good systems in place to ensure that the responsibilities of the Mental Health Act 1983 (MHA) were being followed. However we found a number of shortfalls which we have asked the trust to address.

We found evidence that the responsible clinician (RC) had assessed and recorded their capacity to consent to medication, as well as documenting their discussion about medication and its purpose and effects.

Our findings

Assessment of needs and planning of care

Patients had a comprehensive assessment of their needs upon admission which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.

We looked at 41 sets of patient records across all of the acute and PICU wards. We saw evidence of well documented care plans that described how individual needs were met on admission and at each stage of patient care. Care plans were recovery focused and helped patients receive support to address the symptoms of mental disorder. Care plans included relapse prevention and crisis planning.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward and on an on going basis.

Patient needs and care plans were reviewed on a regular basis at multi-disciplinary team meetings and at allocated Care Programme Approach (CPA) meetings.

Feedback from patients across the wards confirmed they felt involved in decisions about their care and contributed to their care plans through formulation meetings. Patients told us that they were offered copies of their care plans on yellow paper which we observed patients kept in their rooms. We found there was a lack of evidence in the electronic notes system called PARIS of patient involvement in formulating care plans in the majority of care plans that we reviewed.

Patient records were stored securely electronically through a system called PARIS which could be accessed by all staff working across the wards.

Best practice in treatment and care

Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

We found evidence which demonstrated the acute wards had implemented best practice guidance within their

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clinical practice. This included implementation of the National Institute for Health and Care Excellence (NICE) guidance for the psychological treatment of a range of mental illness conditions such as psychosis, depression, anxiety and bipolar disorder. The service was able to offer information and support to people using the service to cognitive behavioural and psychological therapies as guided by NICE. Patients had good access to psychology input with psychologists embedded within the multi-disciplinary teams. Patients with personality disorder had access to dialectical behavioural therapy (DBT) as recommended by NICE guidelines.

Patients had access to the full range of NICE guidelines and information on best practice in treatment which was available on all of the acute and PICU wards. NICE guidance was followed prescribing medication. Where this was not the case, the medical staff ensured this was discussed with another senior member of staff and the reasons clearly recorded for this decision. We saw examples of this in patient records.

The PICU wards were members of the National Association of PICU care which meant that staff had an opportunity to share good practice with other PICUs across England.

We saw areas of good practice being used on the wards such as Trauma Clinical Link Pathway (CLiP) which was a tool being used to assess trauma in patients lives and incorporate this into recovery. There was also 'grounding' toolkits available for wards to use which was box of visual aids used to express past traumas.

The acute and PICU wards used a number of measures to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis. On all the wards we visited we saw examples of audits of care planning, activities, medication, the explanation of people's rights, infection control and prevention measures, and physical health checks. Information from completed audits was fed back to staff, as well as being reported to the ward and governance teams. It was used to identify and address changes needed to improve outcomes for patients.

Skilled staff to deliver care

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice.

Staff we spoke with were positive and motivated to provide quality care. Staff received appropriate training, supervision and appraisal. Staff told us that they received supervision which consisted of both individual management supervision and group clinical supervision. Staff were supported to maintain and further develop their professional skills and experience.

Training for staff consisted of mandatory and more specialist training. The trust monitored the staff in relation to compliance with mandatory training. Each ward manager monitored training uptake and encouraged staff to attend training by distributing training dates and organising time to leave the ward areas to carry out training needed. We saw that where staff were overdue training, systems were in place to provide prompts to ensure this occurred such as email alerts.

There were regular team meetings and staff felt well supported by their manager and colleagues on the ward. Many staff mentioned good team work as one of the best things about the wards.

Multi-disciplinary and inter-agency team work

Patients received well coordinated care from a range of different staff, teams and services. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.

Patients received multi-disciplinary team input from managers, medical staff, registered nursing and non-registered nursing staff and other professionals including occupational therapists and psychologists. Patients on the acute wards had timely access to psychology input, with dedicated inpatient psychologists embedded within the majority of multi-disciplinary teams.

Multi-disciplinary team meetings or formulation meetings occurred on a daily basis and patients were invited to attend at all of the wards we visited. We observed at least one MDT or formulation meeting at each hospital site. We found they were effective in sharing information about people and reviewing their progress. Different professionals worked together effectively to assess and plan people's care and treatment.

There was comprehensive information on each patient to ensure that all members of the nursing and multi-disciplinary team were kept up to date on current issues with patients and to inform decisions about future holistic care needs.

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 were encouraged to take ownership of MDT meetings and encouraged to participate fully.

Patient records showed that there was effective multidisciplinary team (MDT) working taking place. Care plans included advice and input from different professionals involved in patient's care. People we spoke with confirmed they were supported by a number of different professionals on the wards.

We observed inter-agency work taking place, with staff from the community teams, crisis teams, local authority housing workers, inreach substance misuse workers, dual diagnosis workers, approved mental health professionals (AMHPS) and care coordinators attending meetings on the ward as part of patient's admission, MDT meetings and discharge planning.

As part of the TEWV quality improvement system the acute and PICU wards followed the principles of the 'Virginia Mason Production System' an evidence based way of working from Seattle. Part of this included a meeting on each ward called a 'report out'. This was attended by staff in the morning on a daily basis where each patient was discussed using a visual display board looking at current care and risk factors and tasks were set for staff for the day. We attended a 'report out' meeting on each hospital site and found these to be an effective system for ensuring care was patient focussed, therapeutic, informed by risk and formulated with discharge as a focus.

Adherence to the MHA and the MHA Code of Practice

The acute and PICU wards had good systems in place to ensure that the responsibilities of the Mental Health Act 1983 (MHA) were being followed.

All patients were provided with a trust 'Welcome Pack' which included a variety of information leaflets such as, information about the ward, IMHA and IMCA services, advanced decisions and other issues. Patient information leaflets were available on the unit regarding various MHA sections and copies were in patient case files.

The trust utilised an electronic computerised care records system known as PARIS. This system was used across all trust directorates and included a section titled 'Mental Health Legislation'. This section was comprised of various local online mental health forms such as capacity assessments, best interests' assessments and recording of statutory consultees.

All detained patients had a specific care plan in place detailing their detention under the MHA. All patient care records viewed contained evidence that patients had been informed of their legal status and their rights under the MHA at the time of detention, and had been regularly reminded of their rights during their period of detention.

Patients said that they were aware of their rights and demonstrated this knowledge in discussions with us. They knew how to access the IMHA and had made applications to the tribunal.

We found a complete set of mental health act documents including the approved mental health professional's (AMHP) reports on each file. The AMHP reports gave information about each patient's background and the circumstances leading to the assessment.

We noted risk assessments were in place for those patients having authorised section 17 leave. A system was in place to record the outcome of section 17 leave and this formed part of the routine multi-disciplinary meetings (MDT) where the patient's progress was reviewed. We found evidence that patients had copies of their Section 17 leave forms. Staff reviewed leave on a regular basis and were committed to positive risk taking following assessment.

We observed the T2 and T3 certificates were completed legibly, with drugs listed by name or class consistent with the British National Formulary (BNF) category. The required section 61 reports were completed and section 62 forms were completed when urgent treatment was considered necessary.

However we found:

At Stocksdale one patient had been receiving one type of medication not covered by Form T2.The mistake had not been discovered by the audit system in place.

At Overdale:

- One patient no copy of a section 5(2) form was present in their case file
- We noted that a Care Quality Commission (CQC) information poster was displayed in the ward but no CQC information rights leaflets for detained patients were available on the ward.

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.

- For two patients the online statutory consultee forms had only been completed by one consultee. Also the RCs had not completed part of the form to confirm the patients had been informed of the outcome of the SOAD visit.
- For one patient who had been subject to section 5(2) no copy of the form was present in the case file.

At Ward 15:

- One patient's leave form was ambiguous as the parameters and conditions of leave were not clear
- One patient had been prescribed two antipsychotics when only one had been authorised by the T2.
- It was not possible to find evidence that the outcome of leave had been fully documented and we were unable to find evidence that the patient's own view of their leave had been sought or recorded.

At Cedar at the Briary Unit:

- Some patients reported that there had been a delay in providing them with information about their rights in accordance with section 132 on admission.
- One patient had not received a fresh explanation of their rights when detention was renewed.
- Some patients were not clear about their legal status or rights under section 132 of the Act. Some patients informed us that staff had just read out the rights leaflet when attempting to give this information and did not offer any further explanation or check understanding.
- Old and superseded leave forms were found in the current files that need to be removed or struck through.
- Patients informed us that there were occasions when they were unable to access escorted leave that had been authorised as there were insufficient numbers of regular staff available to escort them.

Good practice in applying the MCA

We found evidence that the RC had assessed and recorded their capacity to consent to medication, as well as documenting their discussion about medication and its purpose and effects.

MHA, MCA and Deprivation of Liberty Safeguards (DoLS) training for staff was provided however this was not part of the mandatory training requirement.

However at Overdale no patients had advanced decisions in place.

Good

Are services caring?

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

Summary of findings

We rated the acute and PICU wards as good because:

Patients were treated with compassion and empathy. Feedback received from patients was positive about their experience of the care and treatment provided by the staff. The patients we spoke with were complimentary about staff attitude and engagement. Patients shared a number of examples of how they felt well supported.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care.

Patients using the service had opportunities to be involved in decisions about their care. Patients told us that their care plans were discussed with them, they were encouraged to attend their review meetings and they had a copy of their plan if they wished.

Community meetings were held regularly on the wards.

Patients had regular access to advocacy.

Carers were actively involved in patient's care.

On some of the acute wards there was pilot assessment in place to capture patient views called 'All About Me' this was in use at some wards. This had not been rolled out through all of the acute and PICU wards and where this was absent there was nothing in place for capturing patient's views, hopes, goals and incorporating them into the care plans.

The care plan documents across the trust were found in the electronic patient notes system (PARIS) and from reviewing this it was difficult to see how the involvement of the individual's was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in PARIS.

Our findings

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. We heard staff talking about patients who used the service in a respectful manner during staff handovers and they showed a good understanding of their individual needs.

Staff told us how they made sure they respected people's privacy and dignity. We could see that they spoke to patients politely and ensured doors to bedrooms were closed when delivering personal care.

Feedback received from patients was positive about their experience of the care and treatment provided by the staff. The patients we spoke with were complimentary about staff attitude and engagement. Patients shared a number of examples of how they felt well supported.

Staff we spoke with felt that patients received good care on the wards.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care. We observed a multi-disciplinary handover meeting; patients' needs were discussed and considered with dignity and respect.

The involvement of patients in the care they receive

Patients using the service had opportunities to be involved in decisions about their care. Patients told us that their care plans were discussed with them, they were encouraged to attend their review meetings and they had a copy of their plan if they wished.

The care plan documents across the trust were found in the electronic patient notes system (PARIS) and from reviewing this it was difficult to see how the involvement of the individual was recorded. Patients told us that care was planned and reviewed with them however in some cases this was not evidenced in PARIS.

On some of the acute wards there was a pilot assessment process in place to capture patient views called 'All About Me'. This was in use at some wards at Roseberry Park, Lanchester Road and Sandwell Park. This was not in use at Danby, Esk and Cedar at the Briary Unit. This had not been rolled out through all of the acute and PICU wards and where this was absent there was no process in place for capturing patient's views, hopes, goals and incorporating them into the care plans.

Community meetings were held regularly on the wards. We looked at the minutes from some of these meetings. The

Good

Are services caring?

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

meetings were attended by patients using the service and staff on the ward. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible. At Lincoln ward there was a weekly all staff and patients meeting which was minuted. This allowed staff and patients to discuss how the ward ran. There was a rolling action plan in place to ensure actions were addressed.

Staff were knowledgeable about patients' needs and showed commitment to provide patient led care. Patients felt that they were involved in their care, especially around the 72 hour formulation meetings, a patient led forum where patient care was discussed with the MDT.

Patients had regular access to advocacy from Cloverleaf, including specialist advocacy for patients detained under the Mental Health Act known as Independent Mental Health Advocates (IMHAs). Staff informed patients about the availability of the IMHAs and enabled them to understand what assistance the IMHA could provide with one exception noted. Patients we spoke with were aware of the IMHA service and complementary of the responsiveness and support received from the IMHA.

Carers were actively involved in patient's care as all of the acute and PICU wards followed the 'triangle of care' which ensures staff, patients and carers are fully involved. We could see that carer groups were taking place and were advertised around the ward areas. Carers that we spoke with gave us positive feedback about their involvement in care.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated the acute and PICU wards as good because:

All admissions had clear reason, a development of a clear formulation and a clear plan as to goals to be achieved to facilitate discharge when clinically appropriate.

A clear PICU admission process was in place to ensure this was appropriate, timely and arrangements were in place to transfer patients back to the acute wards when clinically necessary. Systems enabled transfer of patients without delay.

Discharge discussions took place at daily report out meetings with expected discharge dates set and reviewed regularly. We could not however see that discharge plans had been put into place for patients on the acute wards until discharge was imminent.

There were good working links with the community mental health teams (CMHT) to facilitate discharge from the wards. Weekly bed management meetings occurred with representatives from the CMHT to consider discharge planning.

Patients were actively encouraged to participate in a wide range of activities.

Patients' diversity and human rights were respected.

Complaints and concerns were taken seriously and responded to in a timely way and listened to.

Our findings

Access, discharge and bed management

Admissions into the acute beds were gate kept by the associated crisis teams. Approved Mental Health Professionals (AMHPs) completed a Mental Health Act assessment before any patient was admitted. This ensured that there was proper consideration whether people required admission.

The acute wards followed the principles of the Purposeful Inpatient Admission Process (PIPA), a local admission process based on best practice which ensured that all admissions had clear reason, a development of a clear formulation and a clear plan as to goals to be achieved to facilitate discharge when clinically appropriate.

Where admission to the PICU units from an acute ward was required, a clear PICU admission process was in place to ensure this was appropriate, timely and arrangements were in place to transfer patients back to the acute wards when clinically necessary. Ward managers reported good relationships with the two PICU wards at West Park and Roseberry Park and told us that systems enabled them to transfer patients when required without delay.

The PICU pathway was particularly well managed at Roseberry Park where four acute wards and one PICU were located. There was an admission flow chart in place based around the principles of the 'PICU pyramid' which was a care planning approach to engage patient in the management of their behaviours to prevent PICU admission. When a PICU admission was required as a last resort these care plans were in place and ready to be implemented. The plans incorporated measures to proactively encourage patients to move back to the acute ward even before transfer to the PICU had taken place.

Discharge discussions took place at daily report out meetings with expected discharge dates set and reviewed regularly. We could not however see that discharge plans had been put into place for patients on the acute wards until discharge was imminent.

There were good working links with the community mental health teams (CMHT) to facilitate discharge from the wards. Weekly bed management meetings occurred with representatives from the CMHT to consider discharge planning.

Patients were reported to be appropriately placed with no significant issues with delays on discharge. The wards were operating within safe bed numbers at the time of our visit. The majority of wards were Male or female only wards which had available beds for patients where gender segregation was a risk factor.

Are services responsive to people's needs?

Good

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

The ward environment optimises recovery, comfort and dignity

The wards had communal areas and other quiet rooms which could be utilised as private interview rooms. There was a room for family visiting off the wards in all areas which were suitable for children visiting. The wards had access to activities rooms.

There was a good range of information across the wards for patients on notice boards and via a selection of leaflets on a range of matters.

Patients commented favourably on the quality and portions of the food. Patients were given choice of food including vegetarian options. Patients could make hot drinks and snacks with any risks managed on an individual basis.

Weekly activity programmes were advertised on all wards. Support time and recovery workers (STR) and occupational therapists worked across the acute and PICU ward to enable patients to participate in therapeutic activities of daily living with a recovery focus. Staff told us that planned activities were rarely cancelled because of a lack of staff available to run them. Patients were actively encouraged to participate in a wide range of activities.

On the wards we visited we saw patients participating in various activities. There was an active occupational therapy team who engaged patients in activities. The focus was on mental wellbeing and recovery. There were a range of initiatives that patients could get involved in. Occupational therapy support was available five days a week throughout the acute and PICU wards.

At Roseberry Park there were excellent dedicated facilities for activities and occupational therapies called 'Activity Street' incorporating pottery art, cookery, yoga, use of a pool table and musical instruments. There was a gym with a gym instructor available. However staff told us that this was not open as often as they would like due to unavailability of staff and that there was work being done to have staff brought in externally to run the activity street. We looked at the timetable and saw it was only available Monday to Friday from 10 to12am and Monday, Tuesday and Thursday from 12:45 to 2:45pm.

At Lincoln there was a dedicated multi-disciplinary 'intensive support team' providing occupational therapy as a focus for recovery.

All the wards offered access to an outside space, which included a smoking shelter, with the exception of Cedar at the Briary Unit which did not have a shelter.

Meeting the needs of all patients who use the service

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. There were designated multi-faith prayer areas off the ward. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards. Translation and interpretation services were available. Lesbian Gay Bisexual and Transgender (LGBT) issues were actively discussed in some groups as well as specific formulation tools which explored relationships and sex.

The staff respected patients' diversity and human rights. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the wards. Local faith representatives visited people on the ward and could be contacted to request a visit.

Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment. Leaflets explaining patients' rights under the Mental Health Act were available in different languages.

A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to eat appropriate meals.

Listening to and learning from concerns and complaints

Patients who used the service knew how to raise complaints and concerns. Most patients told us they felt they would be able to raise a concern should they have one and believed that staff would listen to them.

Information on how to make a complaint was displayed in the wards, as well as information on the patient advice and liaison service (PALS) and independent advocacy services. Patients could raise concerns in community meetings and this was usually effective.

Are services responsive to people's needs?

Good

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

Staff told us they tried to address patients' concerns informally as they arose. We observed staff responding appropriately to concerns raised by relatives and carers of patients using the service and negotiating solutions. Staff were aware of the formal complaints process and knew how to signpost people as needed to PALS.

Complaints and concerns were taken seriously and responded to in a timely way and listened to. Staff said that learning from complaints was discussed at team meetings and changes had taken place. Improvements were made to the quality of care as a result of complaints and concerns were displayed around the wards under the heading 'You said, We did'.

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.

Summary of findings

We rated the acute and PICU wards as good because:

The trust's vision and strategies for the service were evident and most staff considered they understood the vision and direction of the trust.

The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust.

There were regular meetings for managers to consider issues of quality, safety and standards.

Data was collected regularly on performance. Each acute ward compiled performance data that recorded their performance against a range of indicators and was reported at divisional monthly performance clinics attended by ward managers.

There was opportunity for staff to submit organisation/ team risks to the trust risk register. Not all ward managers however were aware that they could contribute risks to a local risk register specific to their service risks.

There were systems in place to gather feedback form patients on an on going basis through Patient Experience Trackers (PET) which was a tablet computer based on each ward which collected real time feedback from staff, patients and carers. Performance against the results of the PET were analysed on a monthly basis and actions were put into place to ensure that shortfalls were improved upon. Feedback we received from the majority of staff was that the questions asked of patients were not clear and did not capture useful data or lead to useful changes.

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their dedication to providing quality patient care.

Most of the acute and PICU wards were members of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation scheme called AIMS and were accredited with excellence.

Our findings

Vision and values

The trust's vision and strategies for the service were evident and on display in some wards. Most staff considered they understood the vision and direction of the trust. Staff were able to tell us about specific initiatives such as the staff compact, which was an agreement between staff and the trust to provide high quality care.

Ward managers had regular contact with their modern matrons and divisional managers. Staff told us that senior trust managers sometimes came to the wards.

Good governance

The wards were overseen by managers who oversaw the quality and clinical governance agenda. Nursing staff on the wards had lead responsibilities for carrying out checks on various elements of clinical practice such as medicines management, Mental Health Act adherence, records checks, environmental and security checks. Identified issues from these had been shared through team meetings or other forums.

Information about 'lessons learned' was circulated throughout the trust in an e-bulletin sent to all staff. These incidents were discussed in team meetings and at handovers as well to ensure all member of the team were involved.

Where we found issues which had not been picked up or addressed by the trust's own systems, we were assured that managers were already developing plans to address these in better ways to properly identify, address or manage the risks to patients.

There were regular meetings for managers to consider issues of quality, safety and standards. This included oversight of risk areas in the service such as incidents. These were being monitored regularly by senior staff in the service. This helped ensure quality assurance systems were better identifying and managing risks to patients using the service.

The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust. One

Are services well-led?

Good

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example of this was the electronic staff record (ESR) that monitored the training that staff had received and informed staff and their managers when training needed to take place.

The quality improvement system (QIS) provided a framework and approach to continuous quality improvement. The Quality and assurance group (QUAG) provided locality and speciality groups within the trust who were responsible for quality and assurance.

Data was collected regularly on performance. Each acute ward compiled performance data that recorded their performance against a range of indicators and was reported at clinical directorate monthly performance clinics attended by ward managers. These included serious untoward incidents (SUIs) and clinical incidents, safeguarding incidents, Other patient safety incidents, patient experience, complaints and PALS issues, clinical audit and clinical outcomes. Managers could compare their performance with that of other wards and this provided a further incentive for improvement. We saw evidence of improving performance in many areas on all wards.

There were also a number of working groups that make regular reports to QUAG which ward managers attended or had input into. These included

- Patient Safety
- Clinical Audit and Effectiveness
- Patient Experience
- Drugs and Therapeutics
- Research Governance
- Infection Prevention and Control
- Medical Devices
- Safeguarding Adults
- Safeguarding Children
- Psychological Therapies Governance
- Equality and Diversity

There was opportunity for staff to submit organisation/ team risks to the trust risk register. One ward manager however was unaware that they could contribute risks to a local risk register specific to their service risks.

Most staff we spoke with told us they were not involved in clinical audits within their team but had an awareness of trust audits in place.

There were systems in place to gather feedback form patients on an on going basis through Patient Experience Trackers (PET) which was a tablet computer based on each ward which collected real time feedback from staff, patients and carers. Performance against the results of the PET were analysed on a monthly basis and actions were put into place to ensure that shortfalls were improved upon. Feedback we received from the majority of staff was that the questions asked of patients were not clear and did not capture useful data or lead to useful changes. An example of this was a question about the patient's support worker helping them to recover which was confusing because the term 'support worker' was not clear who was being referred to.

Leadership, morale and staff engagement

Staff reported that morale was generally good. Staff told us they felt supported by the management across the services we visited. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their dedication to providing quality patient care.

Staff had clear roles and a management structure that was understood by staff. Most staff reported they liked working at the trust. Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Regular ward meetings were held with minutes recorded.

Commitment to quality improvement and innovation

The service continued to listen and engage with patients on an on going basis to ensure that patients received good quality care that met patients' needs.

Most of the acute and PICU wards were members of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation scheme called AIMS. The CCQI aims to raise the standard of care that people with mental health needs receive by helping providers, users and commissioners of services assess and increase the quality of care they provide. This is done by collecting information from patients, carers and staff about standards of care using national clinical audits, surveys and peer-review visits.

All of the acute and PICU wards were accredited with excellence with the exception of:

- Bedale PICU which had been accredited.

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- Elm which was a member of AIMS but had not yet been assessed.
- Ward 15 which was not a member of AIMS.
- Cedar at the Briary Unit which was not a member of AIMS.

The trust had been named as the provider of the year 2011 by the Royal College of Psychiatrists based on widespread participation in quality improvement programmes. This showed a dedication to quality improvement across the majority of the acute and PICU wards.

Ward 15 was also a member of a 'safer wards' pilot scheme and had also won an award for 'living the values' for involvement with the local community in improving the garden area.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: On Ward 15 we found risk associated with patients and no intervention plans in place related to these risks. This included risk of ligature and self harm. The combination of the environment with multiple ligature points and the increased use of bank and agency staff on the ward who require access to information about risk made this a significant risk. Regulation 9 (3)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: On Ward 15 in the seclusion room there were blind spots identified where patients could remain out of sight of the observing staff. The trust had taken the appropriate action to identify and escalate this environmental concern however this had not been responded to by the estates department from the host trust. Regulation 12 (2)(i)