South West Yorkshire Partnership NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

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

Requires Improvement ➔➔

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the service.

We rated the service as requires improvement, with all five domains of safe, effective, caring, responsive and well led rated as requires improvement.

We visited all of the acute and psychiatric intensive care unit (PICU) wards provided by the trust at the following locations:

The Dales, Calderdale Royal Hospital:

- Elmdale ward, a 24-bed female acute ward
- Ashdale ward, a 24-bed male acute ward

Priestley Unit, Dewsbury and District Hospital:

- Ward 18, a 23-bed mixed gender acute ward

Fieldhead Hospital, Wakefield:

- Nostell ward, a 22-bed female acute ward
- Stanley ward, a 22-bed male acute ward
- Walton PICU, a 14-bed mixed gender PICU

Kendray Hospital Barnsley:

- Clark ward, a 14-bed female acute ward
- Beamshaw ward, a 14-bed male acute ward
- Melton PICU, a 6-bed mixed gender PICU

Our rating of services went down. We rated them as requires improvement because:

- Staffing pressures within some specific staff groups were impacting on the experience of patients and the quality of care they received.
- Physical restraint of patients in the prone position (face down) was used more frequently than national guidance recommends.

Our findings

- People were not always adequately monitored following the administration of emergency medication or while in seclusion.
- People did not always have access to psychological therapies in line with recommended national guidance relating to their condition (for example, individuals with a diagnosis of personality disorder).
- A high proportion of staff were not having regular performance appraisals in line with the trust's appraisal policy.
- Staff were not receiving mandatory training on meeting the needs of people with a learning disability and/or autistic people in line with the national recommendation that all staff working within a CQC registered service should receive this at a level appropriate to their role.
- When people had their capacity to consent to their treatment formally assessed, this was not always appropriately documented in their care records.
- Records did not always show that people using the service and their relatives were meaningfully involved in their care.
- At Kendray Hospital the wards were running at over 100% occupancy (due to the practice of admitting new patients to the bed of someone who was on authorised leave from the hospital) and there had been a number of admissions to non-bedroom areas such as lounges.
- The care environment did not always meet the needs of the patients, particularly where people had additional needs due to protected characteristics such as disability or religion.

However:

- The wards were clean and free from avoidable risks including ligature risks, staff regularly assessed environmental risks and took action to mitigate these.
- Staff complied with best practice in relation to infection prevention and control including hand hygiene and wearing appropriate personal protective equipment.
- Medicines were managed safely and records of the storage and administration of medicines were accurate and up to date.
- Staff were aware of their responsibilities in relation to safeguarding adults at risk of abuse and raised safeguarding concerns appropriately.
- Staff complied with the requirements of the Mental Health Act and the Mental Capacity Act.
- Staff treated people kindly and with respect, we observed positive and supportive interactions between patients and staff on the wards.
- People could give feedback about their experience and changes were made as a result of this. Complaints were investigated in a timely manner and people received a response to their concerns.
- Senior leaders created a culture on the wards where patients and staff felt supported and were able to express their views.
- There were systems in place for monitoring the quality of care and effective assurance processes to inform the trust board of the standard of care on the acute and PICU wards.

How we carried out the inspection

Our findings

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

• visited all 9 wards and looked at the quality of the environment

• spent time on the wards observing how staff were caring for people

• observed a governance meeting and a ward round

• spoke with 33 patients on all 9 wards

• spoke with 12 relatives/carers

• spoke with 7 care co-ordinators for patients on the wards

• received feedback from a independent mental health advocate who visits the wards

• spoke with members of the senior management team including 1 service manager, 1 matron, 7 ward managers and 2 clinical leads

• spoke with 6 doctors including consultants, specialty doctors and junior doctors

• spoke with 25 other staff members including nurses, health care assistants, occupational therapists, activity coordinators, psychologists and discharge coordinators

• looked at the prescription charts for all patients, 20 full sets of care and treatment records and other care records, for example seclusion and restraint records

• looked at a range of policies, procedures and other documents relating to the running of the wards.

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

What people who use the service say

The patients we spoke with gave us a mixture of positive and negative feedback about the service. People mostly told us that the wards were clean, they felt safe and staff managed incidents of aggression well. Some people told us there was always enough staff on duty, but some said the wards were often short staffed and there were a lot of agency workers, particularly on the night shift, which had a negative impact on the quality of their care at times. Most of the people we spoke with said their community leave and/or activities had been cancelled due to staffing pressures on at least one occasion.

People told us that staff treated them kindly and, if they had been subjected to any restrictive interventions such as physical restraint or seclusion, this had been done respectfully and safely. People usually felt they were given enough information about their medicines and said they could access a doctor when they needed to, although some people

Our findings

said there were delays in doctors attending out of normal working hours. Some of the people we spoke with said they felt involved in their care and they were able to give feedback about their experience, but some people felt less involved. People told us that staff gave them privacy as much as possible and they were able to access quiet spaces on the ward. Everyone we spoke with was able to access fresh air sometimes, but patients at The Dales, Priestley Unit and Kendray Hospital had more limited access to outside space, which some people found frustrating.

People gave positive feedback about the occupational therapy support they were receiving overall. Some people said there was not a lot to do on the ward, particularly at weekends. Some people told us that the care environment did not meet their individual needs, for example cultural dietary needs or accessibility needs due to a disability. People knew how to raise concerns about their care and they mostly told us that these were taken seriously and problems were addressed.

The carers we spoke with told us that they were happy overall with the care their relative was receiving in hospital. They said the wards or visiting rooms they saw when they visited were clean and they were able to visit as often as they liked, spending regular time with their relative both at the hospital and away from it (when the person had been granted leave). Relatives told us that most of the staff were kind and supportive towards their family member, although some people told us that individual staff members seemed less interested in their relative, particularly on the night shift.

Several of the carers we spoke with said the ward their relative was on seemed to be short staffed. Some of the people we spoke with said they did not feel that staff kept them informed about their relative's progress or involve them in decisions and most said they had not been offered any information about the support available to them as a carer. Some relatives said they felt there was a lack of organisation and streamlined processes on the wards, which made it challenging for them to keep up with how their relative was doing.

Is the service safe?

Requires Improvement 

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished and fit for purpose.

Safety of the ward layout

Staff usually completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Each ward had a ligature risk assessment which was reviewed annually. All but one of the ligature risk assessments had been signed off by a manager and ratified by the trust's Quality and Governance meeting prior to our inspection. The outstanding risk assessment was completed in October 2022 but had not been signed off by a manager or ratified through the trust's governance processes prior to our inspection. This was completed immediately following the inspection. On Ward 18 we were not able to access the ligature risk assessment on the ward as staff were unable to locate it. Also, not all wards had a copy of the approved and ratified ligature risk assessment as the copy they had was still in draft form. However, staff were aware of where environmental risks were and measures were in place to mitigate these. We were told that the trust was already aware of issues with the sign off process for ligature risk assessments which could lead to delays. We were assured by the trust following the inspection that all wards now had

an approved and ratified copy of their ligature risk assessment stored in accessible folders. The trust has also assured us that following our inspection a system of ward matrons' spot checks was implemented, to ensure staff are aware of the location of these folders and the information contained in the assessments. There was also a fire risk assessment for each ward which had been reviewed in the 12 months prior to our inspection.

Staff could observe patients in all parts of the wards. Where there were blind spots, these were mitigated through the use of mirrors and staff supervision in certain areas, for example the gardens at Kendray Hospital.

All the acute wards apart from Ward 18 were single sex. On the mixed sex wards (Ward 18, Walton PICU and Melton PICU) the male and female bedrooms were on separate corridors and there were female only bathrooms and lounges available.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Door top alarms had been recently installed across all the acute and PICU wards due to the risk of someone using their bedroom door to anchor a ligature. However, these were not in use on all wards at the time we inspected. Where this was the case, we were told this was because staff needed to complete training on the alarms, which was in progress. The trust informed us that this was progressing in accordance with the planned programme of phased implementation of these environmental improvements. The trust confirmed in October 2023 that the door top alarms are now in use on all the acute and PICU wards. Some areas on the wards were kept locked due to the presence of ligature risks in these rooms.

Staff had easy access to alarms and patients had easy access to nurse call systems. Each room had a nurse call point and they were also situated throughout the communal areas on the wards. Staff were issued with portable alarms at the start of their shift.

Maintenance, cleanliness and infection control

Ward areas were clean, well-maintained, well-furnished and fit for purpose. We saw cleaning taking place throughout our time on all the wards we visited. The patients we spoke with on all the wards said the care environment was kept clean and relatives who had visited the hospital also said this. One patient raised concerns about the sofa in the lounge on Nostell ward having a ripped cover. We were told a repair had been requested in relation to this.

Staff made sure cleaning records were up-to-date and the premises were clean. The trust carried out regular audits of the cleaning documentation and the care environment to ensure the premises were being cleaned to an appropriate standard. We saw cleaning records for all 9 wards for the 4 weeks prior to our inspection which showed that regular cleaning and environmental monitoring was taking place during this period. Two of the seclusion rooms at Elmdale and Fieldhead Hospital were not clean when we inspected them. One had food on the floor and a puddle of water in the bathroom and the other had a toilet which was heavily soiled. We were told both these rooms had been vacated earlier that day and requests had been put into housekeeping for them to be cleaned. The cleaning records were broken down by room for the wards at Fieldhead and Kendray and so could provide assurance of regular cleaning of the seclusion rooms. This was not the case for The Dales and Ward 18. However, we did see evidence that environmental audits were in place on Ward 18 which included documented checks of specific ward areas including the seclusion room.

The stairwell at The Dales which patients used to access the secure garden needed refurbishment. The trust confirmed this was scheduled to take place in July 2023. Following the inspection we received photographic evidence from the trust confirming that these planned refurbishment works were completed in September 2023. Clark ward was also in need of refurbishment and we saw evidence that plans were in place for this to start immediately following our inspection. The trust informed us in October 2023 that this refurbishment programme had commenced.

Our findings

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the locations scored better than similar locations across England for cleanliness and for condition, appearance and maintenance across all the trust sites where the acute and PICU wards are based.

Staff followed the infection control policy, including handwashing. At the time we inspected the trust still required staff to wear surgical face masks in clinical areas to limit the risk of spreading COVID-19 within the hospital. We observed staff complying with this requirement.

Seclusion rooms

The seclusion rooms on all four sites allowed clear observation and two-way communication. They all had a toilet and a clock. In the seclusion room on Elmdale ward the ceiling smoke alarms had been removed from the ceiling. We were told this was due to the risks presented by a patient who had vacated the room earlier that day. The alarms were located and replaced while we were on site.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We saw records which confirmed the resuscitation equipment was checked by staff and replenished as needed.

Staff checked, maintained, and cleaned equipment. We saw records which confirmed this in the clinic rooms and we did not identify any equipment which was in need of cleaning or repair during the inspection.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, there were staffing pressures within specific groups which were impacting on patient care.

Nursing staff

The service had enough staff to keep patients safe. The trust's safer staffing data for 2022/23 showed an average shift fill rate of 117% across the acute and PICU wards. Staff and managers told us shifts were usually fully staffed. Some patients told us there were usually enough staff around to meet their needs but some said the wards were often short staffed, particularly at night. All the wards we visited except for Ward 18 were fully staffed when we inspected in terms of overall numbers.

However, some of the staff and patients told us that there were not always enough qualified nurses working on shifts. This was particularly the case at Kendray Hospital and the wards we visited at Kendray were not staffed to full establishment in terms of qualified nurses when we inspected. This resulted in the ward manager of Clark ward being the only qualified nurse on the ward for a period in the afternoon, when the only other qualified nurse included in the shift numbers had to attend a ward round meeting off the ward. Staff on Beamshaw ward also told us that there was not always an experienced nurse on the ward but just one who was shared between Clark and Beamshaw wards. The trust informed us following our inspection that there was only 1 occasion since October 2022 when there was only one registered nurse covering Clark and Beamshaw ward. We were also informed that, since March 2020, there has been senior leadership duty cover for these wards 7 days a week. Some patients at Kendray Hospital told us it was sometimes hard to get the attention of a nurse because they were so busy. Other members of the multi-disciplinary team, for example occupational therapists, told us that sometimes they were counted as part of the ward staffing numbers due to a shortage of nursing staff. Most of the relatives we spoke with told us they felt the wards were short staffed when they visited their family member.

Our findings

The service had low vacancy rates. Across all the acute and PICU wards there was an average vacancy rate of less than 2 whole time equivalent (WTE) staff per ward.

The service had high rates of bank and agency staff. Over the 4 weeks preceding our inspection the average proportion of staff on each ward who were bank or agency workers was 49% on Ward 18, 46% at Fieldhead Hospital, 40% at Kendray Hospital and 33% at The Dales. This included the bank and agency workers needed to bring the ward team up to the minimum safe staffing level and any additional staff needed to cover enhanced observations and other specific needs on the wards.

Some of the patients we spoke with said there were a lot of agency staff and they would like a more stable staff team so they could build more of a rapport with staff members. Some of the staff we spoke with at Kendray Hospital told us there was a high reliance on agency nurses due to vacancies for registered nurses, particularly on the night shift. Patients at Kendray Hospital told us there were too many agency staff working at night and they did not find these staff members as supportive or approachable as the day staff. Staff at Kendray Hospital also raised concerns about some night staff falling asleep during their shift. The ward manager was aware of these concerns and had taken action to address them by sending an email to all staff to remind them of their responsibilities and the trust policy in relation to night work. On the day we inspected Nostell ward there was a high proportion of agency staff on the shift (3 out of 7 staff members were agency workers).

Managers requested bank and agency staff who were familiar with the service. Ward managers told us they tried to use substantive staff picking up additional bank shifts or regular agency staff as much as possible. Staff and patients told us that day staff were usually familiar to them, but sometimes at night the staff team was less familiar due to a high use of agency workers. At Kendray Hospital in particular we were told this put additional pressure on substantive staff, who were understandably favoured by patients over less familiar staff when they needed something.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The wards had induction checklists which were reviewed with agency staff when they worked their first shift on the ward. There was also written information available for agency nurses, although the booklet we saw on Clark ward was out of date as it included information about paper prescription charts but electronic prescribing had been introduced across the service. We did not see any evidence that this had resulted in any medicines errors or inappropriate practice. The trust told us that the booklet was updated following our inspection to accurately reflect the electronic prescribing arrangements on the ward.

The service had average turnover rates. The average rolling 12-month turnover rate for all staff at the time we inspected across the acute and PICU wards was 13%, which was slightly above the trust's target of 10-12%. Some staff told us they felt turnover was high.

Managers supported staff who needed time off for ill health. Staff told us they felt well supported by the trust and they were able to take time off sick if they needed to.

Levels of sickness were mixed. Five out of nine wards were below the national average for NHS services (5.5%) for the period 1 April 2023 to 31 January 2023 and four out of nine were above average for the same period. Where levels of sickness were higher, we were told this was usually due to the impact of the COVID-19 pandemic.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, not all wards were staffed up to full establishment of qualified nurses when we inspected.

Our findings

The ward managers could adjust staffing levels according to the needs of the patients. Ward managers told us that if people's needs changed, for example if a patient needed an enhanced level of observations, they could request additional staff.

Patients did not always have regular one to one sessions with their named nurse. Some patients told us they did not know who their named nurse was and they were not being offered one to one sessions with anyone. Staff told us this was not always possible due to the staffing pressures faced by the wards which sometimes resulted in there being fewer qualified nurses on a shift than the required number in the staffing plan. The trust had tried to mitigate the impact of this by introducing a system where each patient was allocated to a team of nurses and healthcare support workers so that, if their named nurse was not available, they would have access to other familiar and consistent staff for one to one support.

Patients told us that they sometimes had their escorted leave cancelled because there was not a staff member available to support them. The trust stated that whenever this happened it was reported as an amber incident on the Datix incident reporting system, but some of the ward staff we spoke with said they did not think this always happened. A high proportion of the patients we spoke with told us that their leave had been cancelled on at least one occasion due to staffing issues during their current admission. The incident records showed that cancelled leave was reported as an incident on 4 occasions across all 9 acute and PICU wards between 1 April 2023 and 23 May 2023.

The trust prepares an annual report in relation to section 17 leave and the most recent report (2021/22) stated that 98% or more of patients' authorised section 17 leave went ahead as planned in the working age adult, older people and rehabilitation inpatient services (which includes all the acute and PICU wards covered by this inspection). However, due to the feedback we received from patients and staff, we were not assured that the trust's governance processes were capturing all instances of cancelled leave. Staff were prompted to record any cancelled section 17 leave for each patient on the handover record template for some wards but not all. The trust told us that the recording of cancelled leave on the handover template was ward specific, where matrons had identified a need to monitor the issue more closely for assurance. We saw evidence in team meeting minutes from Kendray Hospital that staff had raised concerns about the redeployment of qualified staff between wards which they felt was impacting on patients' section 17 leave at times.

The service had enough staff on each shift to carry out any physical interventions safely. Staff and patients told us they felt safe on the wards. Patients told us staff were effective at de-escalating aggressive incidents and intervening to ensure people were kept safe from harm.

Staff shared key information to keep patients safe when handing over their care to others. Handover meetings took place on all the wards we visited. They were attended by all ward-based staff on the incoming shift and the nurse in charge of the outgoing shift. Records were kept of the information shared at handover, which included a summary of any risks relating to each patient's care, an overview of their activities and mental state during the previous 12 hours and any incidents which had occurred.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency. Ward staff told us they could access a doctor quickly, including out of hours. Patients told us they were usually happy with how often they got to see a doctor but some people told us they had to wait for longer than they wanted, especially if a doctor had to be called out unexpectedly. The relatives we spoke with said they were happy with their family member's access to medical care during their hospital admission.

Our findings

Managers could call locums when they needed additional medical cover. However, this was rarely necessary as all the wards we visited had substantive consultants and junior doctors in post. Some medical staff were working their notice periods, and we were told that recruitment was ongoing to ensure there was no gap in medical provision to the wards.

Mandatory training

Staff had usually completed and kept up to date with their mandatory training. Across the acute and PICU wards overall over 80% of staff were up to date with all mandatory training modules except for cardiopulmonary resuscitation (CPR) training, which was at 74% compliance when we inspected. We were told this was due to the impact of the COVID-19 pandemic on the availability of face-to-face training sessions and there was a recovery programme in place to address this. The trust had also identified other areas for improvement in the provision of mandatory training, for example on three wards less than 70% of staff were up to date with their physical interventions training and there was also targeted work ongoing to address these shortfalls. We were told that ward managers and senior leaders made every effort to ensure sufficient numbers of Reducing Restrictive Practice Interventions (RRPI) and CPR trained staff were allocated to each shift to ensure the safety of patients. Following the inspection the trust informed us that compliance rates for both modules have improved to 83% of staff for CPR training and 86% of staff for RRPI training, as at October 2023.

The mandatory training programme was comprehensive and met most of the needs of patients and staff. All staff were required to complete a mandatory programme of training which was a mixture of e-learning and face to face sessions including safeguarding, CPR, reducing restrictive practice interventions (RRPI), information governance, mental health legislation, equality and diversity, infection prevention and control and health and safety.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers had their own systems for monitoring staff completion of mandatory training and sent out reminders when staff needed to complete updates. The data was also collated centrally and used to drive improvement programmes where particular courses or staff groups were showing as outliers in terms of mandatory training compliance.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and usually followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, restraint was not always carried out in line with national guidance and people were not always adequately monitored during and following restrictive interventions.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The trust used the Formulation Informed Risk Management tool (FIRM) on all the acute/ PICU wards. The trust audited FIRM completion and and the creation of a staying safe plan for each patient to ensure this was taking place promptly following admission. The April 2023 audit showed that over 90% of patients had a completed risk assessment and staying safe plan within the required timescales across all the acute and PICU inpatient services.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Most of the patients we spoke with said staff supported them to be safe at the hospital. However, some patients raised concerns about being able to deliberately

harm themselves on the ward without staff taking action to prevent this or giving them any support on preventative strategies. For one patient, where this was the case, we saw that they had a risk assessment and care plan relating to their deliberate self-harm, but these were focused on how to keep the person safe following the self-harming behaviour rather than any preventative action which the patient or staff could take.

Staff identified and responded to any changes in risks to, or posed by, patients. Risk assessments were reviewed and care plans were updated when people's risks changed, for example following incidents.

Staff could observe patients in all areas of the wards. Blind spots were mitigated with mirrors and measures were in place to restrict access to areas where people could be at risk of serious harm if they were not supervised by staff.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. On all the acute and PICU wards we were told the policy was to only conduct personal searches, including of people's bags, if there was an identified risk that this person may bring banned items on to the ward such as alcohol or illicit substances. None of the patients we spoke with raised any concerns about inappropriate searches of themselves or their bedrooms.

Use of restrictive interventions

Levels of restrictive interventions were low overall. Patients and staff on all wards told us physical restraint did not happen frequently. We requested data from the trust which showed low overall levels of seclusion and restraint on the acute and PICU wards. In relation to physical restraint there were 856 instances across 9 wards in the 12 months preceding our inspection (an average of 8 restraints per ward per month). In relation to seclusion there were 208 instances involving 153 patients on the 7 acute wards and 113 instances involving 66 patients on the 2 PICUs in the 12 months preceding our inspection. Use of rapid tranquillisation was also low, with a total of 84 instances involving 63 patients across all 9 wards in the 12 months preceding our inspection. The patients we spoke with, who had experienced restrictive interventions, told us staff had acted safely and treated them respectfully. One person raised concerns about receiving an injury in a previous restraint. This had not previously been raised and the ward manager immediately took steps to investigate this and report the concern to the local safeguarding team.

However, the trust's data showed a high level of restraint in the prone (face down) position – out of 856 instances of restraint across the 9 wards in the 12 months preceding our inspection, 196 were in the prone position for at least part of the intervention (23%). Staff told us prone restraint was sometimes used to enable staff to safely exit seclusion. This was particularly the case at Fieldhead Hospital (with 50 prone restraints on Walton PICU, 19 on Nostell ward and 19 on Stanley ward) and Kendray Hospital (with 15 prone restraints on Beamshaw ward and 10 on Clark ward). Prone restraint is not recommended practice due to the risk of obstruction of the individual's airway in this position. National Institute for Health and Clinical Excellence guidance on managing violence and aggression in mental health services states that prone restraint should be avoided where possible. The Mental Health Act Code of Practice states that there should be no planned or intentional restraint in the prone position unless there are clear reasons for this.

The trust confirmed that in 2022/23 they had identified reducing prone restraint as a priority area in their governance work around reducing restrictive practices generally. We saw extracts from the trust board and sub-committee minutes which evidenced this. The Reducing Restrictive Practice Interventions (RRPI) team were exploring alternative strategies to prone restraint and introducing an alternative exit method for seclusion which should reduce the use of restraint in the prone position. The RRPI team are also in the process of establishing RRPI champions for each ward to promote

training, best practice, communication and quality improvements. Following our inspection, the trust told us that they had implemented further improvements to reduce the incident of prone restraint on the acute and PICU wards including investment in safety pods, re-accreditation with the Restraint Reduction Network, review of exit strategies from seclusion and improved Datix reporting and data analysis.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. On Nostell ward, a targeted piece of work in line with the Royal College of Psychiatry's Reducing Restrictive Practice Collaborative Programme had been carried out since the last CQC inspection, which had resulted in an overall 60% reduction in restrictive practices and 69% reduction in physical restraints. At the time of our inspection the trust was preparing to roll this project out across the rest of the acute and PICU wards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. People told us staff tried to de-escalate incidents verbally before resorting to physical interventions.

Staff understood the Mental Capacity Act definition of restraint and worked within it. There were a number of informal patients on the wards when we inspected. These patients were given information about their right to leave the ward and we saw no evidence to suggest anyone was being subjected to an unlawful deprivation of their liberty. However, at Kendray Hospital we observed patients frequently having to ask for doors to be unlocked to access lounges and the secure garden. The bathrooms were also locked as there were ligature risks in these rooms and the baths could not be used by patients without staff supervision. Following our inspection, the trust told us that options were being reviewed to have the assisted bath removed and replaced with a standard bath, which could be used without supervision in appropriate circumstances and which would reduce the ligature risks in the patient bathrooms.

Staff did not always follow NICE guidance when using rapid tranquilisation. The trust's template document prompted staff to document checks as recommended by NICE guidance on the short-term management of violence and aggression in mental health settings, however these records were not being consistently completed by staff. At times there were valid reasons for this, for example the patient being in seclusion and too unsettled for staff to be able to enter safely. However, even in these circumstances it is likely to have been possible for staff to record basic information such as the patient's level of consciousness and respiration rate and this was not always documented. Following our inspection, the trust told us that gaps in record keeping following rapid tranquillisation had been identified as an area for improvement in the inpatient service's Quality Priority Plan in April 2023 and that work was already ongoing to address this.

When a patient was placed in seclusion, staff did not always keep clear records to demonstrate they followed best practice guidelines. The seclusion records we reviewed showed staff were not always documenting observations or nursing, medical and MDT reviews at the intervals stated in the Mental Health Act Code of Practice. We were told that the trust was in the process of implementing electronic record keeping in relation to episodes of seclusion. Following the inspection the trust informed us that this was being rolled out across the inpatient services and monitored by the trust's RRPI Action Group. Some of the patients we spoke with who had been secluded during their time on the ward said they were not offered food or drink regularly. Some staff told us they did not think all their colleagues were aware of the intervals at which a patient in seclusion should be reviewed by a doctor or a nurse, because the seclusion policy was too long and complicated. Following the inspection, the trust told us that the intervals at which patients must be reviewed by a doctor or nurse are clearly set out on an easy read flow chart within the Seclusion Policy and these charts are also displayed on the walls of the seclusion areas on all wards.

Our findings

There were no patients in long-term segregation on the acute or PICU wards when we inspected. The data provided by the trust showed that there were two instances of long-term segregation across all 9 wards in the 12 months preceding our inspection.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Training on safeguarding children and adults from abuse was part of the trust's mandatory training programme for all staff. The trust safeguarding team had also recently provided safeguarding supervision sessions to staff at The Dales.

Staff kept up-to-date with their safeguarding training. The trust's training data showed that 83% of staff were up to date with safeguarding adults training and 87% of staff were up to date with safeguarding children training across the acute and PICU inpatient services at the time we inspected.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The staff and patients we spoke with did not raise any concerns about patients experiencing any discrimination on the grounds of race, gender, sexual identity or any other protected characteristic. Staff told us there was a zero tolerance policy in relation to hate crime on the wards.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The staff we spoke with told us their training had equipped them with the knowledge they needed to identify concerns about abuse and report them appropriately. They were able to give examples of things they would report as safeguarding concerns and they could describe the procedure for doing so, for example completing body maps and following the trust's safeguarding reporting process. The records of safeguarding referrals showed that a range of concerns about potential abuse and neglect of vulnerable people were being identified and referred to the relevant local safeguarding teams.

Staff followed clear procedures to keep children visiting the ward safe. There were designated visiting areas separate from the main wards where child visitors could spend time with their relative safely.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The managers and staff we spoke with about safeguarding were able to clearly describe the process for raising concerns and were aware of their personal responsibility to raise safeguarding concerns as soon as possible. The records confirmed safeguarding concerns were identified and referred to the appropriate local authority.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. All the wards used the same electronic record keeping system and this could be accessed from staff laptops and desktop computers on all wards.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff on all wards had access to the patient's records from their community care and any previous inpatient admissions, where these were provided by the trust.

Our findings

Records were stored securely. Staff used smart cards and passwords to access the system and we observed staff ensuring screens were locked before they walked away from desks.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The trust used an electronic prescribing system which was in use on all acute and PICU wards. Staff told us they were finding this system, which had been recently introduced, beneficial in supporting them to manage medicines safely. The trust's pharmacy team carried out quarterly audits in relation to medicines management, most recently in January 2023, which demonstrated medicines were being managed safely across all acute and PICU wards. The trust confirmed that, at the time we inspected, all registered nurses had received training and competency assessments in relation to using the electronic system. However, due to the way medicines training was recorded (at individual ward level), we were not able to see training records which evidenced this. The trust confirmed conversations were taking place between the Directorate of Nursing, Quality and Professions and the pharmacy team to agree how to strengthen the monitoring and oversight of medicines management training.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw evidence in people's records that their medicines were reviewed by their responsible clinician at regular multi-disciplinary ward rounds. Most patients told us they were happy with the information they had been given about their medicines, but some people said they were not given enough information, for example about side effects. Following the inspection, the trust informed us that all patients are offered information about potential side effects to their medicines on admission and on an ongoing basis throughout their admission.

Staff completed medicines records accurately and kept them up-to-date. We reviewed the prescription charts for all patients on the electronic system and we did not identify any prescribing or administration errors.

Staff stored and managed all medicines and prescribing documents safely. The prescribing system was password protected and only accessible from designated terminals. We inspected the clinic rooms on all acute and PICU wards and we found that medicines were being stored safely and appropriately.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. All the wards received input from a pharmacist, who was responsible for reviewing patients' medication when they were admitted to the wards.

Staff learned from safety alerts and incidents to improve practice. Information on lessons learned from medicines errors was shared with staff in team meetings and via email updates.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The use of 'as required' medicines was reviewed during patients' ward rounds to ensure this was not being used excessively or to control behaviour. At Kendray Hospital we were told that some of the night staff offered 'as required' medication more frequently and some patients felt this was to make sure they had a quiet night. The ward manager was aware of these concerns and action was being taken to ensure staff working at night were monitored and any concerns were addressed. Following our inspection, the trust informed us that PRN medication usage is reviewed in each patient's ward round and regular use would trigger a review to consider if a regular prescription or a change to the patient's care planning was warranted.

Our findings

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When people were taking medication which had the potential to impact their physical health, due to the type of medication or the dose prescribed, regular physical observations were usually taking place as required, although we identified one record where the commencement of a high dose anti-psychotic was prescribed and physical health monitoring checks had been recommended but not actioned.

Track record on safety

The service had a good track record on safety.

There were no incidents investigated at the trust's highest 'serious incident' level on the acute and PICU wards in the 12 months prior to our inspection. There were 3 incidents investigated at the next most serious 'service level investigation' level. There were 3 patient deaths related to the acute and PICU wards in the 12 months prior to our inspection – two of these were due to natural causes. The cause of the third death (which occurred while the patient was undertaking unescorted section 17 leave in the community) was not known at the time of our inspection.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The hospital used the Datix incident reporting system and all the staff we spoke with about incidents confirmed they were confident using this and they knew what types of event should be reported.

Staff reported serious incidents clearly and in line with trust policy. The staff we spoke with confirmed they used the trust's Datix system to report untoward incidents and they were aware of what needed to be reported as an incident.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The trust monitored compliance with the duty of candour in its weekly performance audit on all acute/PICU wards.

Managers debriefed and supported staff after any serious incident. Managers told us that de-briefs would be arranged for staff following serious incidents, with input from the ward's psychology team as needed. We saw evidence that a programme of ongoing support was implemented for staff following a particularly serious incident on Clark ward.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incident investigation reports included details of how the patient and/or their relatives had been involved in the incident investigation, including the opportunity for people to contribute to the scope of the investigation and the specific questions which would be considered.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received emails which included lessons learned from incidents. The hospital also had a system of 'Blue Light' alerts, which were used to highlight learning from serious incidents to staff, we saw examples of these prominently displayed in ward offices.

Our findings

Staff met to discuss the feedback and look at improvements to patient care. Themes and trends from incidents were regularly escalated to the trust's Quality and Governance meeting and the trust shared details of improvement work carried out due to incident data analysis including the introduction of safety huddles across the acute and PICU wards, a sexual safety initiative on Ward 18 (a mixed gender ward) and a reducing restrictive practice collaborative on Nostell ward.

There was evidence that changes had been made as a result of feedback. For example, following a serious incident where a patient had successfully fixed a ligature to a ligature-safe bathroom fitting using Blu-tack, the trust had added Blu-tack to the banned items list for all wards. This restriction was in place on all the acute and PICU wards and was being complied with (for example through safer methods being used to display information on ward noticeboards). The staff we spoke with were aware that Blu-tack was not allowed on the ward and the reason for this.

Managers shared learning with staff about never events that happened elsewhere through the trust's system of issuing 'Blue Light' alert notices. We saw these notices being displayed on some of the wards we visited to ensure the information was highlighted to staff. The alerts were also accessible to all staff on the trust's intranet.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were holistic and recovery-oriented, however they were not always adequately personalised.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All the records we reviewed included evidence of a comprehensive assessment of the patient's mental health needs. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. People were receiving physical observation checks using the NEWS2 early warning system at least weekly, and more frequently if they had physical health conditions which required an enhanced level of monitoring.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. People usually had care plans in place on their records relating to their health and social care needs and any specific risks relating to their care. However, people did not always have care plans in place relating to individual needs arising from their protected characteristics, for example gender identity, when this would have been appropriate.

Staff regularly reviewed and updated care plans when patients' needs changed. All the care plans we reviewed had either been written or updated recently.

Care plans were holistic and recovery-orientated. Care plans were bespoke for each patient rather than being on pre-written templates. All the sets of records we reviewed included a discharge plan which included meaningful information about how the patient was being supported in their pathway to leaving acute inpatient care. However, it was not always possible to see how the patient's voice was being captured in the care plans and there was little clear evidence of patient

involvement in the planning of their care. Following our inspection, the trust informed us that a care plan and risk assessment improvement group is working to address this and to ensure, where it is not possible for a patient to be involved in their care planning, that this is referenced and consideration is given to who could be involved on their behalf.

Best practice in treatment and care

Staff provided a range of treatment and care for patients, however this was not always based on national guidance and best practice. Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. There was a written standard operating procedure (SOP) for both the PICU and acute services which was informed by a range of relevant national best practice guidance including from the Department of Health, NHS England and the National Institute for Health and Clinical Excellence. However, some of the guidance referenced in the SOPs were out of date, for example the PICU SOP refers to the Standards for Better Health, which were superseded when the Health and Social Care Act 2008 came into force. We did not see any evidence that this had resulted in a negative impact on patient care, and the trust informed us following the inspection that this had been addressed.

Staff usually delivered care in line with best practice and national guidance. However, we identified some occasions where people's individual needs were not being met because they were not receiving the level or type of psychological support which would be nationally recommended best practice in light of their diagnosis, for example a lack of psychological therapy provision for some patients who had a diagnosis of personality disorder. Some of the staff we spoke with said they felt the psychology provision on the wards could be improved. Following our inspection, the trust informed us that access to direct psychological support for patients has been improving since 2022, with new appointments made at consultant psychologist and senior psychologist levels, as well as an increase in assistant psychologists in post. This has enabled an increase in the provision of one to one psychological assessment and therapy, group therapies, complex case clinical supervision, debriefing sessions and supervision for MDT staff and trust wide liaison and service development work to improve person-centred psychosocial support.

Staff identified patients' physical health needs and recorded them in their care plans. People had specific care plans for long-term physical health conditions, for example diabetes.

Staff made sure patients had access to physical health care, including specialists as required. People with long term physical health conditions had care plans relating to their needs and their records showed they were receiving input from relevant services. People told us they felt well supported in relation to their physical health.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. People had their risk of malnutrition assessed on admission and had their food and fluid intake monitored where required. All patients were weighed weekly to ensure they were not losing or gaining unhealthy amounts of weight during their admission.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients at all of the 4 sites we visited had access to a gym which they could attend with staff support whether or not they had been granted section 17 leave. The gym on Ward 18 was closed for refurbishment when we inspected, but we were told that patients were able to access the gym on Ward 19. The patients we spoke with told us the occupational therapists offered good support in relation to healthy lifestyle choices.

Our findings

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The Health of the Nation Outcome Scale (HoNOS) was used and we saw completed HoNOS assessments on the records we reviewed.

Staff used technology to support patients. On some wards a mobile application was being used by lead nurses and matrons to carry out spot checks in relation to a range of quality indicators. The application could then be used to generate reports which were used to inform the board assurance processes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Each ward was overseen by a modern matron and part of their role was to monitor the quality of the care plans. This was done through a process of random 'dip' sampling on a weekly basis. More detailed audits were also carried out on specific wards, for example to test the implementation of learning following changes to practice or an untoward incident.

Managers used results from audits to make improvements. Each ward had a quality priority plan which pulled together learning from a number of sources, including audits, to ensure actions were taken to address lessons learned and identify priorities for improvement.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care, although staffing pressures within particular groups had led to patients not always having access to the support they needed. Managers supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, staff were not always supported with regular performance appraisals.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Patients on all the wards we visited were receiving care from a multi-disciplinary team of professionals including psychiatrists, mental health nurses, occupational therapists, psychologists and physiotherapists.

However, we saw evidence that staffing shortages within the occupational therapy team were impacting on the availability of regular therapeutic activities on the wards and in the community. The activity timetables for some of the acute/PICU wards for April and May 2023 showed that on multiple days during the week there were no organised activities taking place. Walton PICU and all wards at Kendray Hospital were running on a reduced timetable in May 2023 due to staffing pressures. Activities were also cancelled on 4 occasions in the 2 months prior to our inspection due to staff unavailability. Following our inspection, we were told that sickness absence and staff vacancies had been impacting the occupational therapy teams at Kendray Hospital, Fieldhead Hospital and Priestley Unit at the time of our inspection. The trust has advised us that this staffing position has improved since our visit and additional therapeutic activities are now taking place on these wards.

Some of the people we spoke with raised concerns about there not being much to do on the wards and we also saw this had been raised at recent community meetings. Some patients mentioned additional activities they would like to be able to do, such as art and cooking. Some of the staff we spoke with said the staff shortages had caused them to experience work-related stress due to the expectation that they would support patients with activities which would usually be led by the occupational therapy team in addition to their usual duties. The trust stated that one to one activities were offered by ward staff to mitigage the impact of this and recruitment campaigns were ongoing to fill the occupational therapy vacancies as soon as possible.

Our findings

The trust had also started a collaborative community project with a social enterprise made up of artists to provide accessible art sessions to patients on all the acute and PICU wards. This was done to improve the offer of meaningful activities and to reduce the number of incidents taking place at weekends, when historically there had been fewer activities on offer. We received positive feedback from patients about these sessions on the wards where they had commenced.

Managers usually ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, we did find there was often a shortage of registered nurses working on the wards compared to the numbers of nursing associates, trainee nursing associates and support workers. Ward managers were aware of this and recruitment was ongoing to increase the numbers of registered nurses working in the acute and PICU service.

Managers gave each new member of staff a full induction to the service before they started work. Substantive staff completed a comprehensive induction and we saw evidence that when new bank and agency workers worked their first shift on the ward they completed an induction checklist with a permanent member of staff.

Managers did not consistently support staff through regular, constructive appraisals of their work. The appraisal data for the acute and PICU wards showed appraisals were not taking place in line with the trust's appraisal policy (which recommends annual appraisals). On six out of the nine acute and PICU wards, less than 30% of staff had received an appraisal in line with the trust's policy at the time we inspected. The lack of compliance with the trust's appraisals policy across the acute and PICU wards was recognised by the trust in March 2023 and in response to this the service managers had developed a wellbeing plan, which included a review of the appraisal system as a key action. Following our inspection, the trust told us that, by September 2023, 100% of staff were up to date with their appraisals except for on Ward 18, where compliance was at 96% due to staff sickness absence.

Following the inspection the trust shared additional evidence with us to demonstrate that all the acute and PICU wards are working to a target of completion of all registered nurses' appraisals for 2022/23 by 30 June 2023 and healthcare assistants' appraisals for the same period by 14 July 2023. We received updated appraisal figures from the trust which showed that implementation of this plan was positively impacting the number of completed appraisals, which were over 80% complete on 4 of the 9 wards by June 2023.

Managers supported staff through regular, constructive clinical supervision of their work. In quarter 4 of 2022/23 all the acute/PICU wards ensured they met the trust's supervision compliance target of 80%, with 7 out of 9 wards being 100% compliant. In quarter 1 of 2023/24, which was still ongoing at the time of our inspection, 6 out of 9 wards were at 90% compliance or over and the other three were on track to be compliant by the end of the quarter.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The permanent staff members we spoke with said they were able to attend team meetings and they also received email updates. However, regular bank staff said they did not always receive updates following team meetings. We were told that this was not always possible as bank staff may work on different wards and that significant updates are cascaded to bank staff through handovers, ward notices and a range of staff bulletins.

Managers identified any training needs staff had and gave them the time and opportunity to develop their skills and knowledge. Most of the staff we spoke with told us they usually had time to complete their mandatory training modules

within working hours. Staff also gave us examples of specialist training they had received to support them in their roles, for example in relation to particular physical health conditions. Ward managers confirmed staff were able to request training and said registered nurses received an annual allocation of funding from the trust for training and professional development.

Managers made sure staff received some specialist training for their role. Ward managers told us specialist training had been offered to staff, for example physical healthcare training and psychological therapies. However, the nationally recommended Oliver McGowan Mandatory Training on Learning Disability and Autism had not yet been rolled out across the trust as a mandatory training module and no staff working on the acute and PICU wards had completed this training at the time we inspected. The trust told us that staff had access to learning disability and autism e-learning, however this was not a mandatory training module at the time of our inspection. It is a requirement of the Health and Care Act 2022 that regulated healthcare providers must ensure all staff receive learning disability and autism training at a level appropriate to their role and the Oliver McGowan training package is the nationally recommended training which is designed to ensure compliance with this. The trust's Education and Training Governance Group approved the adoption of this training as a mandatory module in April 2022 and the trust was in the planning stages of this piece of work at the time we inspected, with a target for 60% of the workforce to have received this training in the first year of the roll out.

Managers recognised poor performance, could identify the reasons and dealt with these. The ward managers we spoke with were able to describe how they would deal with performance and disciplinary issues in a proportionate way, to ensure staff were supported and people using the service were protected from harm.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multi-disciplinary ward round meetings were taking place at all four sites during the week we inspected. These meetings were attended by staff from all disciplines within the multi-disciplinary clinical team as well as the patient and their advocate if needed. The care co-ordinators we spoke with told us they were usually invited to the patient's ward rounds.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handovers took place on the wards twice a day and information was shared between the outgoing and incoming staff to ensure any changes to people's needs or the risks relating to their care were highlighted. Records were kept of handovers and these records were easily accessible to staff in the ward offices. However, we identified some variation in record keeping relating to handovers due to the template documents being different for each ward.

Ward teams had effective working relationships with other teams in the organisation. We were told that the introduction of the lead nurse role on the acute/PICU wards had improved partnership working between teams across the service line and more widely within the organisation.

Ward teams had effective working relationships with external teams and organisations. Commissioning case managers and care co-ordinators were usually invited to attend the ward round meetings and arrangements were made for them to use video-conferencing facilities. The care co-ordinators we spoke with told us they had a positive working relationship with the MDT at the hospital and could give examples of collaborative working, for example for patients approaching discharge from the ward.

Our findings

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them. However the requirements of the Code of Practice were not always complied with.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff we spoke with about the Mental Health Act had a level of knowledge of the Act which was appropriate for their role.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The trust had a team of Mental Health Act administrators who the ward staff could access for advice and support as needed.

Staff knew who their Mental Health Act administrators were and when to ask them for support. All the managers and staff we spoke with were aware of how to access the trust's Mental Health Act administrators and said they were helpful in supporting staff with Mental Health Act queries.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Ward staff had access to these via the trust intranet.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw evidence that Independent Mental Health Advocates (IMHAs) regularly visited all the acute and PICU wards. Patients told us they were able to speak with an advocate when they wished. The trust produced an annual Independent Mental Health Advocacy report – the most recent version of this showed a 95% rate of compliance with the IMHA requirements in the Mental Health Act and Code of Practice in the 2021/22 financial year. This report also showed that 477 patients across the trust's inpatient services saw an advocate in quarter 1 of 2022/23, an increase from 309 in the previous quarter. The advocate who shared feedback with us said senior staff worked well with them and were supportive of advocacy on the wards, but individual members of ward staff could be less accommodating of advocates, making advocates and patients feel like advocacy was an inconvenience and failing to inform them of the times of patients' ward rounds.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw evidence in the records that people were reminded of their rights under the Mental Health Act (or as an informal patient) regularly. People told us they had been given information on their rights in a format they could understand. The trust audited patients' records to ensure people were being regularly reminded of their rights and the August 2022 report showed a rate of 95% compliance with the requirements of the Mental Health Act and Code of Practice across the inpatient services as a whole (including detained patients and informal admissions).

Staff did not always make sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The trust's annual report on section 17 leave accessibility from February 2023, which covered the period from 1 April 2021 to 30 December 2022, showed that at least 98% of all episodes of approved leave went ahead in each quarter during this period across the acute and PICU services. However, we were told by some members of staff and patients that sometimes staffing pressures prevented patients with only escorted section 17 leave from leaving the hospital as frequently as recommended by their responsible

clinician and therefore it is possible that the trust's governance systems were identifying all instances of cancelled section 17 leave, for example if specific occasions of cancelled leave were not being reported as incidents on the Datix incident reporting system. Following our inspection, the trust told us that all wards plan staffing levels to meet patient needs and can request or plan additional staffing to support patient leave where this is planned in advance.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. This was monitored by the trust in the annual consent to treatment audit, which showed people had access to SOADs as required by the Mental Health Act.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. These records were stored centrally with the trust's Mental Health Act administration team. Ward staff were able to access these on request.

Informal patients knew they could leave the ward freely and the service displayed posters to tell them this. All the informal patients we spoke with were aware of their right to leave the ward whenever they wished. Posters relating to informal patients' rights were not displayed on all the wards we visited, but all patients received a pack of written information, including informal patients' rights, on admission and were reminded of their rights regularly.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. All the records we reviewed included a discharge plan. People's care co-ordinators were involved in their multi-disciplinary ward round meetings so that plans could be made for any after-care they were entitled to following discharge.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The trust audited a number of aspects of compliance with the Mental Health Act including access to advocacy, consent to treatment, access to section 17 leave and information sharing about rights.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed capacity for patients who might have impaired mental capacity. However, capacity assessments were not always clearly documented on people's records.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The staff we spoke with had a good understanding of the requirements of the Mental Capacity Act if a patient did not have the capacity to make certain decisions about their care.

There were no deprivation of liberty safeguards applications made in the 12 months preceding our inspection. Managers and staff confirmed there were no informal patients on the wards who would be prevented from leaving at the time we inspected.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff were able to access the full suite of trust policies from the wards via the trust intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Ward managers confirmed that the Mental Health Act administration team was also available to support staff with queries about the Mental Capacity Act.

Our findings

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. People told us they were given verbal and written information about their care that they were able to understand.

Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision. Not all the records we reviewed included clear records of capacity assessment, including where the patient needed to make an important decision and we would have expected to see a documented assessment of their decision making capacity relating to this. The trust's annual report on consent to treatment from January 2023 identified that 17% of the records reviewed as part of this audit did not include a documented assessment or statement relating to the patient's capacity to consent and only 23% of the records included a full capacity assessment in addition to a statement of capacity. The report included recommendations for improvement work to ensure that staff clearly documented their assessment of the individual's capacity to consent to their treatment. Following our inspection, the trust informed us that the lead matron had undertaken a review of two randomly selected records per ward and had identified no concerns in relation to staff following the trust policy when undertaking a capacity assessment where this is required and documenting it clearly. The trust stated that a formal audit will be undertaken to confirm these findings and this will be shared through the trust-wide Clinical Governance Group.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw evidence on the records of best interests meetings taking place if decisions needed to be made on behalf of someone who lacked capacity.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. The trust's Mental Health Act Committee received a quarterly report providing statistical analysis on the use of the Mental Capacity Act 2005 and concordance with the trust's policies relating to mental capacity. This report included a specific section relating to the Mental Capacity Act and exception reports of any instances of failing to comply with the legislative requirements were provided to the committee. This governance process had led to the planned improvement work in relation to documentation of capacity assessments referred to above.

Is the service caring?

Requires Improvement 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. On all the wards we visited we saw staff treating patients with respect. Support with personal care needs was provided in a discreet way.

Staff gave patients help, emotional support and advice when they needed it. Staff at all levels including managers were responsive to patients who were in distress or who asked for support. People told us they felt that staff were there to support them if they needed it.

Our findings

Staff supported patients to understand and manage their own care treatment or condition. The patients we spoke with told us the medical and ward staff had explained their diagnosis and treatment to them in a way they could understand. Written information was provided to patients on admission to each ward to help them understand the care and treatment they would be receiving.

Staff directed patients to other services and supported them to access those services if they needed help. People told us they had been supported to access other services, for example drug and alcohol services and community projects.

Patients said staff treated them well and behaved kindly. Most of the people we spoke with said the staff were compassionate and treated them really well. People said things like "nothing is too much trouble" and "some staff go above and beyond". Some patients said that occasionally the night staff were not as friendly, for example if a lot of agency staff were working who were not familiar with the ward.

Staff usually understood and respected the individual needs of each patient. We observed some positive and supportive interactions on the wards which showed staff knew the patients well and understood their individual needs. However, we did identify some isolated instances where individual patients were not being fully supported if they had specific needs, for example due to a specific diagnosis or cultural needs, as detailed elsewhere in this report.

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All the staff we spoke with told us they would feel confident to raise concerns if they observed a colleague treating a patient in a way they felt wasn't right.

Staff followed policy to keep patient information confidential. We did not observe staff discussing patient care in communal areas inappropriately. Records were stored securely and we observed staff complying with best practice in relation to information governance.

Involvement in care

Records did not always show that staff meaningfully involved patients in care planning and risk assessment, however they did actively seek patient feedback on the quality of care provided. The trust ensured that patients had easy access to independent advocates but ward staff were not always supportive of advocacy.

Involvement of patients

Staff usually introduced patients to the ward and the services as part of their admission. Ward managers told us patients had an orientation to the ward with a member of staff on admission. Most patients said they had been shown round the ward when they were first admitted but some people said this had not happened. Patients were also given written information when they were admitted to the ward which included a range of useful information.

It was hard to see from the care records how much staff involved patients or gave them access to their care planning and risk assessments. The format of the care plans and risk assessments did not support the entry of meaningful information about patients' views. Some of the people we spoke with said they felt involved in their care planning, but some people said they did not feel involved and had not been offered a copy of their care plans. Some people said they did not feel they had enough time in ward rounds to express their views about their care or ask questions. The advocate we spoke with shared some concerns about staff not giving patients the opportunity to speak in ward rounds and said they were not always told when ward rounds were taking place so they could attend to support the patient's involvement. Following our inspection, the trust informed us that a care plan and risk assessment improvement group is

working to improve record keeping of patient involvement in care planning and we saw evidence of how this is being monitored through the trust's governance processes. The trust also advised that a My Ward Round booklet has been developed on Walton PICU to support patients in considering the topics they may wish to discuss at their ward round. This was well received by patients and as a result is now being rolled out.

Staff usually made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). We observed a ward round where an interpreter was involved to support the patient in understanding the information shared, which was an example of good practice in meeting individual needs.

Staff involved patients in decisions about the service, when appropriate. Community meetings were taking place regularly on the wards and when people were involved in the meetings this was noted in their care records. Some of the patients we spoke with told us they had been involved in decisions about the ward and they were aware that the community meetings were taking place regularly.

Patients could give feedback on the service and their treatment and staff supported them to do this. People were given information in their ward information packs about how to give feedback about their care. Regular community meetings were held on each ward and we saw minutes which showed people were able to raise a range of issues at these meetings with the support of staff. Some of the people we spoke with told us they attended the community meetings and this was also documented in people's daily care records. Staff also kept records of feedback received from other sources, for example written feedback submitted on the wards and online feedback to ensure any trends arising from this could be identified and addressed.

Staff usually made sure patients could access advocacy services. Independent mental health advocates regularly visited the wards and the patients we spoke with confirmed they were able to access an advocate when they needed to, including to support them at their ward round meetings. However, the advocate we spoke with felt that ward staff were not always supportive of advocacy.

Involvement of families and carers

Staff did not always support, inform and involve families or carers. The patients we spoke with who wanted their families to be involved in their care said they felt the staff on the ward supported and informed their families well. However, some of the relatives we spoke with said they did not feel staff kept them informed. Some relatives said it was hard to get hold of someone on the ward when they called and others said the systems on the ward felt chaotic. Others were happy with the level of information and support they recelved from staff as a family member of someone on the ward. Following our inspection, the trust shared information with us about ongoing improvement work in relation to relative and carer involvement. This includes the roll out of carers awareness training for staff, membership of the Carers' Trust Triangle of Care scheme since July 2023, additional information provided to family carers and improved monitoring of record keeping in relation to carer and relative involvement.

Staff did not always help families to give feedback on the service. Some relatives we spoke with told us they were able to express their views about their relative's care, but others said it was harder to be involved.

Staff did not always give carers information on how to find the carer's assessment. A written information booklet for carers had been produced on Ward 18, Priestley Unit, but this did not include any information on how to access a carer's assessment. The carers and family members we spoke with all told us they had not been given any information about the support available to them as carers.

Our findings

Is the service responsive?

Requires Improvement 

Access and discharge

Staff did not always manage beds well. A bed was not always available when a patient needed one. However, patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

There were significant pressures on the acute and PICU beds, particularly at Kendray Hospital. Beamshaw ward was running at over 100% occupany when we inspected (due to some patients being on long-term section 17 leave in preparation for discharge and other patients having been admitted to these bedrooms). There had been occasions when a new patient had been admitted to a non-bedroom area at Kendray Hospital, such as the small quiet lounges, the extra care area adjacent to the seclusion suite and, on one occasion, the seclusion suite itself (with the door open). Ward staff told us this increased the pressures on them due to no additional staff being allocated to the shift to account for the additional work required to nurse a patient in a non-bedroom area. The advocate we spoke with told us that patients had raised concerns with them about this as well. Following our inspection, the trust told us that these admissions were made in order to facilitate care as close to home as possible for people who urgently needed an inpatient admission, in recognition of the potential negative impact which can result from out of area hospital admissions. We were also informed that beds of patients who are on section 17 leave are only used for new admissions following a risk assessment and a review of the likelihood of the patient's leave being rescinded.

The trust shared data with us which showed that between May 2022 and April 2023 all acute and PICU wards were running at an average occupany of over 90% and 4 of the 9 wards were running at an average occupany of over 100% due to the practice of admitting patients to beds which were still nominally occupied by patients undertaking longer term section 17 leave in preparation for discharge from the hospital. This particularly affected the male wards, all of which had an average occupancy rate of over 100% for this period. Staff at Kendray Hospital told us they were concerned that sometimes patients chose not to go on leave because they did not want to risk losing their bed.

When people had been assessed as requiring admission but a bed was not immediately available, a risk assessment was carried out and a package of wrap around care was put in place to ensure they were kept safe and cared for as intensively as possible in the community while awaiting admission. Shortly prior to our inspection, in May 2023, the trust implemented a new data monitoring system which enabled them to monitor waiting times for admission to the inpatient wards.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Rates of delayed discharge were low – at the time we inspected there were 6 patients across all 9 wards who were clinically ready for discharge but whose discharge had been delayed. In all 6 cases this was due to non-availability of safe and suitable accommodation for them to move on to in the community and the trust provided a summary of the actions being taken to ensure the person was discharged as soon as possible. The average length of stay for the 12 months prior to our inspection was less than 70 days on all acute and PICU wards (with a range of 41 to 67 days).

Our findings

The service had low out-of-area placements. Out of 159 patients on the acute/PICU wards when we inspected, 7 were placed by commissioning authorities outside the area covered by the trust. In all 7 cases this was due to the patient's community placement and therefore GP practice being outside the geographical area covered by the trust, but care coordination responsibilities for all these patients remained with the trust.

Managers and staff worked to make sure they did not discharge patients before they were ready. People told us they felt supported in relation to the plans for their discharge from hospital. However, when patients went on leave there was not always a bed available when they returned. This had happened on 2 occasions since 1 April 2023 at the time we inspected. This led to a patient who had to come back from leave unexpectedly having to spend a night sleeping in a non-bedroom area on a mattress on the floor. The trust told us following our inspection that there had been no further admissions to a non-bedroom area at Kendray Hospital between May and September 2023. The trust informed us that patients are only admitted to a non-bedroom area where this is unavoidable, in the patient's best interests and for the shortest possible time.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interests of the patient. The staff we spoke with told us that people were not usually moved between wards. None of the patients we spoke with raised any concerns about being transferred between wards inappropriately.

Staff did not move or discharge patients at night or very early in the morning. Managers told us transfers and discharges would take place within daytime hours unless a transfer at less sociable hours was unavoidable.

Managers told us people could usually be transferred from the acute wards to one of the trust's PICUs if they needed more intensive care.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Rates of delayed discharge were low and we saw evidence that staff were taking action to progress people's discharges as quickly as possible. Patients did not usually have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. All the records we reviewed included a discharge plan and progress towards discharge was reviewed in patients' multi-disciplinary ward rounds. Several managers and members of staff said the trust's discharge coordinators played a really valuable part in expediting discharges and addressing any barriers to people moving on from the wards. The care coordinators we spoke with told us the ward staff worked collaboratively with them in relation to people's discharges.

Staff supported patients when they were referred or transferred between services. The patients and staff we spoke with did not raise any concerns about how transfers between the trust's services and further afield were managed. The care coordinators we spoke with told us the trust communicated with them well when their patient was transferred between wards.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward usually supported patients' privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could usually make hot drinks and snacks at any time. However, the care environment did not always fully meet people's needs.

Our findings

Each patient had their own bedroom, which they could personalise. People did not usually personalise their rooms due to the short-stay nature of the wards. There were no shared rooms and most of the rooms also had an en suite toilet and shower. There were two rooms which were not en suite and there was a bathroom immediately adjacent to these rooms.

Patients had a secure place to store personal possessions. Patients had lockable cupboards in their rooms.

Staff used a full range of rooms and equipment to support treatment and care. However, people did not always have unrestricted access to these. At Kendray Hospital the activities room was in a separate occupational therapy suite which could only be accessed with staff supervision. We were told this was because it was a central facility which was used by more than one ward and therefore staff supervision was required to ensure patient safety due to patient mix and environmental risk management factors.

On Ward 18 the activities room and gym were closed due to ongoing refurbishment and patients had expressed frustration about the length of time this had been going on for in recent community meetings. Staff on Ward 18 acknowledged that the lack of space had impacted on the provision of patient activities. We were told that patients had access to the gym on Ward 19 and could partake in activities in other areas of the ward to mitigate the impact of this. Following our inspection we were told that the refurbishment works had progressed and were due to complete in October 2023.

On some wards we were told there were not enough private rooms for patients to meet with staff one to one. Patients on Stanely ward told us there used to be an art room which they had enjoyed using but this was not there anymore. Following our inspection the trust informed us that the art room on Stanley ward was not closed permanently and was due to re-open in October 2023. During the time it was closed, art supplies remained available to patients to use in other areas of the ward.

Some patient areas were still being used as staff 'hydration stations' due to the requirement for staff to wear surgical face masks in clinical areas to minimise the risk of COVID-19 transmission within the hospital. We were informed following the inspection that this policy had been changed and the areas designated as hydration stations had all been restored to patient use.

At The Dales there were some privacy issues with the environment because there was no privacy screening on the windows which overlooked the garden, which was shared with Ashdale ward, or on the windows of a small patient seating 'pod' which overlooked the main hospital car park. Following our inspection, we were told that plans were in place for the replacement of these windows with glazing units containing integral blinds.

The service had quiet areas and a room where patients could meet with visitors in private. All the wards we visited had separate quiet lounges and private rooms to meet with visitors. On Clark ward the quiet lounge was kept locked due to the individual risks of one patient. We were told if other patients wished to access this they just had to ask staff to let them in. The relatives we spoke with confirmed they were able to meet with their family member in private, but relatives of patients at Kendray Hospital said that staff had to wait outside the room because the visiting rooms were not on the wards.

Patients could make phone calls in private. Patients were allowed their own mobile phone on the ward unless there were particular risks relating to this for the individual. If a patient did not have access to their own phone then there was a phone room or a ward mobile they could use.

Our findings

All the wards had outside space but patients could not always access these easily. The secure garden areas at Kendray Hospital, Priestley Unit and The Dales were locked and could only be accessed with staff support. We were told that this was due to environmental risks in these secure gardens, which could only be mitigated by staff supervision for some patients. While we were on these wards we observed patients frequently having to ask if they could access the garden areas. Some of the people we spoke with at Kendray Hospital and on Ward 18 told us they did not have as much access to outside space as they would like as staff were sometimes too busy to facilitate this. The garden at The Dales was shared between the male and female wards so patients could only access this at designated times. Some of the patients we spoke with at The Dales also said they wished they could have more access to outside space. The patients we spoke with at Fieldhead Hospital told us they could freely access the secure gardens.

Patients could usually make their own hot drinks and snacks and were not dependent on staff. However, we were told on Melton PICU that people had to ask staff if they wanted a hot drink. Following our inspection the trust informed us that this is not usual practice on Melton PICU and was the result of a temporary blanket restriction due to the needs of an individual patient on the ward at the time we inspected. The trust has confirmed that this restriction has now been removed and patients on Melton PICU are able to make their own hot drinks.

The service offered a variety of good quality food. We saw menus for the 4 weeks prior to our inspection which showed people on all wards had a range of healthy and nutritious dietary options, including options to meet specific dietary needs such as vegan, gluten free and Halal menus. We were also told that patients had access to fresh fruit and other snacks between mealtimes. The people we spoke with mostly said the food was good and they had plenty of choice, including vegetarian options. However, some people said there was not much variety and several people told us that they were not always able to access food which met their cultural and religious needs, including Halal food not always being available. Some of the relatives we spoke with said their family member had told them the food wasn't great.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work as much as possible, bearing in mind the short-stay nature of the service and how acutely unwell many people were.

Staff helped patients to stay in contact with families and carers. The written information packs provided to patients when they were admitted to all the wards included information on visiting times and other advice on how to maintain contact with family members and friends. All the family members we spoke with confirmed they were able to keep in regular contact with their relative throughout their admission.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. We saw that most patients had access to community leave and they were utilising this to engage in a range of activities in the community and to keep in touch with their families and friends.

Meeting the needs of all people who use the service

The service did not meet the needs of all patients as the care environment did not always meet the needs of those with a protected characteristic. However, staff usually helped patients with communication, advocacy and cultural and spiritual support.

Our findings

The service could usually support and make adjustments for disabled people and those with communication needs or other specific needs. However, we identified a lack of accessibility for wheelchair users at Priestley Unit. On other wards, some of the people we spoke with told us that they struggled to access some areas, such as the dining rooms, due to mobility impairments.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The information packs provided to all patients on admission included this information and there was also information about rights and the trust's complaints process displayed on noticeboards on all wards except Ward 18 Priestley Unit (which was undergoing renovation). We were told following our inspection that the noticeboard on Ward 18 has now been replaced.

The service had access to information leaflets available in languages spoken by the patients and local community. Staff were aware of how to access these online if people needed them.

Managers made sure staff and patients could get help from interpreters or signers when needed. We observed a ward round where a patient was supported by a British Sign Language interpreter and it was also clear from patients' records they had access to interpreters where needed.

The service usually provided a variety of food to meet the dietary and cultural needs of individual patients. The menus for the 4 weeks prior to our visit showed that people had access to food to meet a range of dietary and cultural needs. However, some patients told us they did not always have access to food which met their needs, for example Halal food for Muslim patients.

Patients did not always have access to spiritual, religious and cultural support. Although all the wards had a multi-faith room on site, these were separate from the locked ward and some people told us they were not always able to access as much spiritual support as they would like. Following our inspection, the trust told us that there is additional support in place for patients' spiritual, religious and cultural needs, including regular visits by faith leaders to inpatient areas, pastoral counselling, ongoing support from trained volunteers and mindfulness and self-compassion courses.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The patients we spoke with told us they knew how to complain about their care and said they had access to advocacy to support them with this as needed. Written information on how to raise a complaint was included in the information packs provided to all patients on admission.

The service clearly displayed information about how to raise a concern in patient areas. This was displayed on the noticeboards on all wards except Ward 18 Priestley Unit. We were told this was because some of the noticeboards on this ward had been taken down due to the ongoing refurbishment of this ward. The ward information pack provided to all patients on admission included information on how to raise a complaint, including on Ward 18. The trust confirmed following our inspection that the noticeboard on Ward 18 had also been replaced due to completion of the refurbishment works.

Staff understood the policy on complaints and knew how to handle them. The staff members we spoke with knew how to support people to raise concerns both informally and formally through the trust's complaints process.

Our findings

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The people who we spoke with, who had raised a complaint, told us they had received a response. The trust monitored compliance with the timescales for responding to patient complaints.

Managers investigated complaints and identified themes. The trust received 33 formal complaints in the period 1 May 2022 to 30 April 2023. The trust's records showed these complaints had been fully investigated unless this was not possible due to the patient not confirming their consent to their records being reviewed.

Staff protected patients who raised concerns or complaints from discrimination and harassment. The patients we spoke with who had raised a complaint about their care did not feel they had experienced any discrimination as a result of this.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they received emails with information on lessons learned from incidents and complaints. We also saw evidence in team meeting minutes that patient feedback was shared with staff.

The service used compliments to learn, celebrate success and improve the quality of care. A spreadsheet of compliments received was maintained (30 were received in the period from 1 May 2022 to 30 April 2023) and staff told us they sometimes received feedback about compliments received about their ward during team meetings.

Is the service well-led?

Requires Improvement 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. The trust's values and a summary of patients' rights were clearly outlined in the written information packs provided to all patients on admission. Staff on all wards told us managers promoted a positive culture for people using the service. Following media coverage of cultural concerns arising at another mental health trust, the trust introduced weekly 'culture conversations' within the modern matron team to increase the likelihood that any concerns about the culture on the wards would be promptly identified and addressed.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. We observed ward managers and more senior leaders interacting with patients on the wards, showing a genuine interest in their wellbeing and any feedback they wished to share. Several of the carers we talked with spoke positively about the support and communication they had received from ward managers, clinical leads and more senior leaders during their relative's admission.

Leaders and senior staff were alert to the culture in the service and as part of this spent time with staff and patients discussing behaviours and values. The trust's governance processes included a range of quality assurance systems which included senior leaders (up to and including members of the executive team) spending time on the wards and speaking with patients and staff.

Our findings

Managers promoted equality and diversity in all aspects of running the service. None of the staff we spoke with raised any concerns about discrimination or unequal treatment due to any protected characteristic. We saw evidence that action was taken to support staff who experienced verbal discriminatory abuse at work, for example racist comments.

We observed a meeting of the senior leadership team at The Dales. The service managers, clinical leads and ward managers worked effectively together to share information and enable flexible partnership working across the whole service.

Vision and strategy

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

Ward managers were able to describe how they made the trust's vision and values meaningful to the staff on the wards. Staff members were aware of the trust's vision and values and could describe how they used these to inform how they supported people.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff received equality and diversity training as part of their mandatory training package. However, not all staff had received learning disability and autism training in line with nationally recommended best practice.

Staff felt able to raise concerns with managers without fear of what might happen as a result. All the staff we spoke with said they would feel comfortable raising concerns and they did not fear any negative treatment if they did. Ward managers told us how they worked hard to promote an open and blame-free culture on their wards.

Staff felt respected, supported and valued by senior staff, which supported a positive and improvement-driven culture. Staff at all levels within the organisation told us they felt valued as trust employees and they were happy with the level of support available to them from managers and colleagues.

Governance

Our findings from the other key questions usually demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. However, we found inconsistency across the wards in relation to how information was recorded, which led to areas where quality issues were not being consistently identified or addressed.

Governance processes were usually effective and helped to hold staff to account, kept people safe, protected their rights and provided good quality care and support. There was a clear reporting structure from 'ward to board' with clinical and operational managers for each site who worked together effectively to ensure the quality of care was continuously monitored and any improvement issues were addressed promptly.

However, we found inconsistency across the wards in relation to how information was documented. For example, cleaning records did not always prompt staff to document the cleaning of individual areas so it was not always possible to use these records for assurance that the wards had been thoroughly cleaned. On some wards specific booklets were used to document seclusion checks but on others these were documented on the patient's electronic progress notes. We found that nursing, medical and MDT checks in compliance with the Mental Health Act were not consistently being documented when people were secluded. Following our inspection the trust informed us that a review of the electronic

record keeping system for episodes of seclusion has been commenced across the acute and PICU wards to ensure that seclusion records include complete and accurate records of the checks carried out. We also found physical health checks in accordance with national best practice guidance were not being consistently documented following rapid tranquilisation of patients. The trust's governance systems may not have identified the extent to which section 17 leave was being cancelled due to staffing pressures, as concerns about this were reported to us by patients and staff on the wards which were not reflected in the number of reported incidents of cancelled section 17 leave. Some of the handover meeting templates prompted staff to record if each patient had experienced cancellation of their section 17 leave and some did not.

Staff used recognised audit and improvement tools to good effect, which resulted in people achieving good outcomes. Each ward had a quality priority plan which enabled managers to track the implementation of improvements driven by learning from audits, complaints, incidents and feedback. These plans were reviewed and updated by managers at monthly governance meetings.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed. It was clear from people's care records that risk assessments and care plans were regularly reviewed and updated as people's needs changed.

Senior staff understood and demonstrated compliance with regulatory and legislative requirements. The trust's governance processes included ongoing assessment of compliance with legislation including the Mental Health Act, the Mental Capacity Act and the Health and Social Care Act.

Staff acted in line with best practice, policies and procedures. They understood the importance of quality assurance in maintaining good standards. Improvement projects were delivered using recognised quality improvement methodology, such as Plan, Do, Study, Act (PDSA) cycles. These resulted in demonstrable improvements on the wards, for example the implementation of a new safety huddle process on Ashdale ward.

Information management

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

At the time of our inspection the trust's lead matron was taking part in NHS England's Quality Transformation Programme for Mental Health, Learning Disability and Autism services. Ashdale ward was involved in the Yorkshire and Humberside Patient Safety Collaborative (PSC) work that formed part of the NHS England's Mental Health Safety Improvement Programme and the National Collaborative Centre for Mental Health (NCCMH) in Reducing Restrictive Practice (RRP).

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

We saw evidence of the trust working in partnership with other providers within the local health economy both at executive level and on individual wards. People using the service and their families had opportunities to become

involved in the development of the service. The wards usually worked well in partnership with advocacy organisations, which helped to give people using the service a voice and improve their health and life outcomes. We also saw local arrangements for partnership working, such as links between individual wards and local safeguarding teams and police forces.

Learning, continuous improvement and innovation.

The trust shared a number of examples of innovative practice and continuous improvement with us including:

- A collaborative project with a community organisation, which had been introduced on all the acute and PICU wards to improve the offer of meaningful activities and to reduce the number of incidents taking place at weekends, when historically there had been fewer activities on offer. We received positive feedback from patients about these sessions on the wards where they were already taking place.
- A project focusing on safer discharge from hospital, working collaboratively with community services to review and improve discharge practices from the wards, interpreting learning from serious incidents and developing business intelligence reports to support safer discharge processes.
- Nostell ward's participation in the Royal College of Psychiatry's Reducing Restrictive Practice Collaborative Programme, resulting in an overall 60% reduction in restrictive practices and a 69% reduction in physical restraints on this ward.
- A pilot project to improve pharmacy provision to the acute and PICU wards at Fieldhead Hospital, by enhancing patient experience and understanding around pharmacological treatment and improving processes of medication dispensing.
- A pilot on Clark ward to improve the provision of trauma-informed care and to develop a trust-wide framework for this, co-produced by managers, ward staff and patients.
- A quality improvement project on Beamshaw ward in partnership with the trust's quality improvement and assurance team to reduce instances of violence and aggression on the ward.
- Participation by some of the physiotherapy team in a community research project around promoting physical activity as a route to improving mortality rates for people diagnosed with a mental illness.

The development of sensory and autism friendly practice within the occupational therapy team at Kendray Hospital, including the provision of additional training on sensory integration and the creation of a sensory room for patients.

Our findings

Outstanding practice

The introduction of a new role of lead nurse on all acute and PICU wards had been very positively received by staff as providing a range of benefits including establishing links between the wards, sharing good practice, supporting with complex cases, peer supervision and support. The lead nurse for Stanley ward won the trust's Leader of the Year award for 2022 and the lead nurse for Walton PICU received a highly commended award in the same category in 2023.

Several of the managers and members of staff on the wards praised the discharge coordinators, which was also a relatively newly created post. We were told how these members of staff played a valuable role in addressing the complex challenges which could impact on people moving on from the wards once they were well enough to leave, which also relieved some of the pressures on ward managers.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that people have care plans in place to meet their needs and minimise any risks relating to their care, taking into account best practice guidance relating to their diagnosis and their individual circumstances including any protected characteristics (Regulation 9(1) and (3)).
- The trust must ensure that people (and, where relevant their relatives and/or carers) have the opportunity to be meaningfully involved in their care, are supported to access independent advocacy and are offered a copy of their care plans, unless this is not possible due to the person's individual circumstances (Regulation 9(1) and (3)).
- The trust must ensure that action is taken to reduce the number of restraints in the prone position which are taking place on the acute and PICU wards, in line with the Mental Health Act Code of Practice and national clinical best practice guidance (Regulation 12(2)(b)).
- The trust must ensure that monitoring checks are carried out in line with national guidance to the greatest extent possible on each occasion following the administration of rapid tranquilisation and when patients are secluded (Regulation 12(2)(b)).
- The trust must ensure that staff receive regularly updated training on cardiopulmonary resuscitation and responding to violence and aggression (Regulation 12(2)(c)).
- The trust must ensure that action is taken to address the patient flow issues impacting on bed occupancy rates and admissions, particularly at Kendray Hospital, to reduce the reliance on leave beds for new admissions and prevent the need to admit patients to non-bedroom areas (Regulation 15(1)(c)).
- The trust must ensure that the planned refurbishment works at Kendray Hospital, Priestley Unit and The Dales are progressed as quickly as possible to ensure patients on these wards have access to a care environment which meets their needs, including those relating to any protected characteristic, and where they are not subject to avoidable restrictions on their freedom of movement within the ward (Regulation 15(1)(c)).

Our findings

- The trust must ensure that the care environment on all wards supports patients' privacy and dignity, particularly when wards are overlooked by areas accessed by patients of another gender or the general public (Regulation 15(1)(c)).
- The trust must ensure that, when a patient's capacity to consent to their treatment or to make another important decision is assessed, a record of this assessment and the outcome is kept within their care records (Regulation 17(2)(c)).
- The trust must ensure that sufficient numbers of appropriately qualified staff are available to meet people's holistic needs during their admission, including the provision of regular meaningful and therapeutic activities for patients both on the wards and away from the hospital if the patient is granted leave (Regulation 18(1)).
- The trust must ensure that there are sufficient numbers of registered nurses on each shift to meet patients' needs and provide an appropriate level of support to unqualified staff, in line with the established staffing ratios for each ward (Regulation 18(1)).
- The trust must ensure that action is taken to address the current high rates of bank and agency staff working on the acute and PICU wards and to ensure that the use of agency and bank workers does not negatively impact on the quality of patient care (Regulation 18(1)).
- The trust must ensure that staff receive regular appraisals in line with the requirements of the trust's appraisal policy (Regulation 18(2)(a)).
- The trust must ensure that staff receive training on meeting the needs of people with a learning disability and autistic people at a level appropriate to their role (Regulation 18(2)(a))
- The trust must ensure that record keeping in relation to environmental risks is kept up to date and is available for ward staff to refer to when needed. (Regulation 17(2)(b)).
- The trust must ensure that, when patients are secluded, they receive observations and medical, nursing and MDT reviews at the intervals stated in the Mental Health Act Code of Practice and clear records are kept to evidence this (Regulation 17(2)(c)).

Action the trust SHOULD take to improve:

- The trust should ensure that staff complete their training on the door top alarms so these can be implemented across all acute and PICU wards as soon as possible.
- The trust should ensure that the written information for agency workers at Kendray Hospital is reviewed and updated to include accurate information on the trust's medicines management systems.
- The trust should ensure that more accessible records are kept of medicines management training and staff competency assessment to provide high level assurance that all staff who require these training updates are receiving them.
- The trust should ensure that clear records are kept on all wards of instances where section 17 leave is cancelled due to staffing pressures and that action is taken to address any concerns identified from this data.
- The trust should ensure that patients are able to access medical care as quickly as possible when this is needed, including out of hours.
- The trust should ensure that all patients who meet the criteria for enhanced physical health monitoring due to their medication start receiving these checks as soon as possible following the prescription of the medication.

Our findings

- The trust should ensure that the restrictions on patients' access to certain areas of the wards at Kendray Hospital are kept under regular review and kept to the minimum level of restriction necessary to keep people safe from avoidable harm.
- The trust should ensure that care plans for people at risk of deliberate self-harm include guidance for staff on how to support the person to minimise the risk of them resorting to self-harming behaviour as well as guidance on how to support them if self-harm does occur.
- The trust should ensure that patient feedback on the availability of food to meet dietary and cultural needs is taken into account when menus are planned for all wards.
- The trust should ensure that patients are able to access hot and cold drinks and snacks at all times on all acute and PICU wards unless this has been individually risk assessed as unsafe.
- The trust should consider amending the cleaning records template for The Dales and Priestley Unit to align with the other trust services and provide assurance that specific areas of the ward are being regularly cleaned in line with the trust policies.
- The trust should consider reviewing the seclusion policy to make this more accessible for staff to use in practice.

Our inspection team

The team that inspected the service included a CQC lead inspector, 2 other inspectors, 1 assistant inspector, 1 specialist nursing advisor, 1 specialist medical advisor and an expert by experience. The inspection team was overseen by Sheila Grant - Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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

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

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury