Leicestershire Partnership NHS Trust

Inspection report

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Date of inspection visit: 25 to 27 May 2021, 2 June 2021, 29 June 2021, 5 to 6 July 2021
Date of publication: 29/10/2021

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of Leicestershire Partnership NHS Trust because at our last inspection we rated two mental health services provided by this trust as inadequate, four mental health services and one community health service as requires improvement. We rated the trust as inadequate for well-led overall.

At this inspection, we visited the two mental health services previously rated inadequate and one mental health service previously rated as requires improvement.

We also inspected the well-led key question at provider level for the trust overall.

At this inspection, two of the three mental health services we inspected improved overall. We rated all three mental health services inspected as requires improvement overall.

At this inspection the overall ratings for mental health services stayed the same in safe, effective and responsive, which we rated as requires improvement. Caring stayed the same, rated as good. The rating for well-led in mental health services, improved to requires improvement.

At this inspection the well-led provider rating improved from inadequate to requires improvement.

We inspected three mental health inpatient services because of the ratings from the previous inspection. All three service inspections were unannounced.

We inspected all key lines of enquiry in all domains (safe, effective, caring, responsive and well-led) in two services. These services were:

- acute wards for adults of working age and psychiatric intensive care units and
- long stay or rehabilitation wards for working age adults.

Our findings

We inspected all key lines of enquiry in two domains (safe and well-led) in a third service. This was:

- wards for people with a learning disability or autism.

We also assessed if the organisation is well-led and looked at areas of governance, culture, leadership capability and improvement. Our inspection approach allows us to make a judgement on how the trust's senior leadership leads the organisation and the provider level well-led rating is separate from the ratings of the services we inspected.

We did not inspect the following core services previously rated as requires improvement:

- community health inpatients services
- community based metal health services for adults of working age
- mental health crisis services and health-based places of safety
- specialist community mental health services for children and young people.

We did not inspect the following core services previously rated as good:

- forensic inpatient or secure wards
- child and adolescent mental health wards
- wards for older people with mental health problems
- community based mental health services for older people
- community based mental health services for people with a learning disability or autism
- community health services for adults
- community health services for children and young people, and
- community end of life care.

We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

In rating the trust overall, we took into account the current ratings of the 12 services not inspected this time.

Our overall rating of this trust stayed the same. We rated them as requires improvement because:

- The trust leadership team had not ensured that all requirements from the last inspection had been actioned and embedded across all services. This meant some fundamental standards were not being met. This included environmental improvements, shared sleeping accommodation, response times to maintenance issues, care planning and access to relevant therapies in certain services. Improvements were noted in some wards in core services but not all. Senior leaders in core services we inspected, had not maintained oversight of improvement across all wards of their services.
- In two of the core services inspected, the environment had not been well maintained. This was highlighted in the previous inspection. Maintenance teams did not undertake repairs in a timely way and not all areas used by patients were clean. Some patients continued to share bedroom spaces in dormitories, and personal belongings were stored on the floor because of limited storage provided by the trust.

Our findings

- Not all patients on acute wards for adults of working age could summon help from staff if required. There was no patient alarm access in four ward areas, including the dormitories. Following inspection, the trust submitted an action plan to review access to call alarms.
- In all three services, not all staff were up to date with mandatory training. Staff who delivered training had been redeployed away from training during the COVID-19 pandemic, but face to face training had restarted and not all staff who had out of date training had rebooked.
- Staff had not managed all risks to patients in services. Staff did not always follow trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff on the acute wards were not consistent with searching patients upon return from unescorted leave as some patients had managed to take lighters onto four of the wards. The service did not have a system in place to monitor the number of lighters each ward held. This was an issue highlighted at our inspection in 2018. At the Willows, six out of 19 patient's risk assessments had not been updated. At the Agnes Unit, staff did not always record the physical health of patients who had been given rapid tranquilisation. In addition, staff did not record the maximum dose of medications a patient could have in any 24-hour period.
- Patient access to psychology and occupational therapy was less than expected on acute wards and rehabilitation wards due to the number of staff vacancies in therapy positions. The lack of psychology was an issue highlighted at our 2018 inspection.
- Two core services did not promote patient centred care in all aspects of care delivery. In rehabilitation wards, staff did not always develop and review individual care plans. Not all care plans reflected patients' assessed needs, or were personalised, holistic and recovery oriented. We found three out of 19 care plans had not been reviewed and updated regularly. On acute wards, not all informal patients knew their rights.
- Staff did not consistently promote dignity and respect as expected in all services. Curtains were missing from bed spaces and staff did not wait for an answer from patients before entering rooms on acute wards. On rehabilitation wards, staff did not care plan the needs of a patient with protected characteristics. In two services, staff were not always caring towards patients.
- The trust had not responded in a timely way to eliminate shared sleeping arrangements (dormitories). On four wards in acute wards for adults of working age, there were shared sleeping arrangements for patients. The trust was told to address the arrangements for eliminating dormitories at our last inspection in 2018 and work had started on one ward in March 2021. Whilst there was a plan to eradicate the dormitories across the trust, there were delays to the timetable and patients continued to share sleeping accommodation which compromised their privacy. Following inspection, the trust submitted an action plan to review shared sleeping arrangements.
- Managers did not successfully cascade information down to all ward staff in acute mental health services. Staff we spoke with were unaware of incidents and learning on other wards across acute wards for adults of working age; this was highlighted as an issue at our inspection in 2018. In the same service, managers did not always review incidents in a timely way.
- Governance systems and processes, and the strategy of the organisation had been extensively reviewed since our last inspection but was not fully embedded into services. Some managers had access to key performance data and could respond to areas of improvement, but this was not consistent in all aspects of care delivery and across all services. For example, issues found in risk assessments, care plans and environmental concerns had been addressed in some services, but not all since our last inspection.

However:

Our findings

- In July 2019, the new trust board formed a buddy relationship with a mental health and community health service NHS trust in Northamptonshire (Northamptonshire Healthcare NHS Foundation Trust – NHFT) following the previous inspections in 2018 and 2019. This became a formal group working partnership in April 2021. A new chief executive was appointed as a shared role between the two trusts. The trust had made significant improvements to develop a strengthened vision and strategy.
- Following the appointment of a new chief executive a new trust board was formed. We noted how much time the new executive team had invested in making and implementing improvements during the COVID-19 pandemic.
- The Step up to Great strategy identified key priority areas of focus which were linked to the trust's vision.
- Governance processes had improved since our last inspection and operated effectively at trust level to ensure that performance and risk were managed well. There were clear responsibilities, roles and systems of accountability to support good governance and management.
- A positive culture had developed since our last inspection. Staff told us they felt happy and enjoyed their work. There was good staff morale in services. Staff felt respected, supported and valued and we heard how well the trust supported staff during the COVID-19 pandemic. Leadership behaviours were fostered, and development of staff was encouraged. There was an extensive wellbeing offer available to staff.
- Engagement with external stakeholders had significantly improved since our last inspection. The trust had key roles in the development of health and social care system working, and collaboration with other care providers to improve provision of mental health services. The trust ensured that people who used services, the public, staff and external partners were engaged and involved in the design of services.
- Equality diversity and inclusion matters had been a focus of the new trust leadership team.
- Medication management had improved significantly across the services. There were improved systems and processes to manage storage, disposal and administration of medications.
- Services had complied with guidance on eliminating mixed sex accommodation. Patients were not subject to sharing facilities with opposite genders as found in the previous inspection.
- Infection prevention and control (IPC) was well managed and monitored and services were responsive to deal with frequent changes in IPC requirements during the pandemic.
- Seclusion environments were not an issue of concern at this inspection. Staff documented seclusion well in most services, compared to our last inspection.
- Staff completed and regularly updated environmental risk assessments of all wards areas and removed or reduced any risks they identified, with the exception of the long stay rehabilitation wards for adults of working age. Staff followed procedures to minimise risks where they could not easily observe patients.
- Patient involvement in planning care was now in place and the voice of the patient in changes to services had been considered.
- There was a good working relationship between the Mental Health Act (MHA) administration team and the wards, community teams and the executive team. This had continued during the pandemic.
- The trust had robust arrangements in place for the receipt and scrutiny of detention paperwork. The scrutiny process was multi-tiered, which included the nurse, Mental Health Act administrator and medical scrutiny. The trust had developed checklists to assist staff with the receipt and scrutiny process.

Our findings

- There had been only one out of area placement over 14 months. This was a significant improvement since our last inspection which reported 171 out of area placements lasting between two and 192 days. In rehabilitation services, staff had effective working relations with the new rehabilitation community transition support team created in response to the pandemic to facilitate faster discharges from the wards.
- Services treated concerns and complaints seriously, investigated them and learned lessons from the results. Managers shared the outcome of complaints with their ward teams.
- The trust board, heads of departments and senior leaders had access to the information they needed to manage risk, issues and performance across the trust.

How we carried out the inspection

During the inspection, our inspection teams carried out the following activities across 11 wards in the services:

- reviewed 64 care records
- reviewed 53 medication records
- interviewed 73 staff and 13 managers
- interviewed 35 patients
- spoke with 15 family members or carers of patients
- checked 5 clinic rooms
- attended 5 meetings
- observed 10 episodes of care
- reviewed the mental health act detention papers of 23 patients and seclusion records of 10 patients, and
- received 41 comment cards from patients that were available for patients to complete during the time of our inspection.

During our well-led inspection, we spoke with 32 senior leaders of the organisation and looked at a range of policies, procedures and other governance documents relating to the running of the trust.

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

What people who use the service say

On Heather ward patients said that there was not enough ventilation on the wards. The matron opened some vault windows via a remote. They later told us that this had been an ongoing concern for around five years. Two patients told us they had experienced cancelled leave, and numerous staff confirmed that facilitating escorted leave had been difficult at times which had led to either a cancellation, or where possible delayed leave. Three patients told us of times when staff had been rude, threatening and disrespectful towards them.

We spoke with five informal patients at the Bradgate Mental Health Unit who were unaware of what they could and could not do as an informal patient. One patient told us they did not know they could leave the ward to seek medical attention. Beaumont ward did not have a poster displayed around informal patients and rights as a patient had ripped it down.

Our findings

Two patients we interviewed on Ashby and Heather wards told us that staff did not always knock on their bedroom doors before entering. One patient on Thornton ward told us that while staff did knock, they did not wait for a response before entering, which had resulted in staff walking into their room while they were changing their clothes, compromising their privacy and dignity.

One patient told us that staff had been rude, threatening and disrespectful towards them, which a relative also confirmed. One ward matron told us that a patient had recently alleged that a staff member had assaulted them. Ward matrons were looking into these alleged incidents.

One patient on Watermead ward told us that a staff member had ignored them when they had asked them for a sandwich.

Six further patients across Beaumont, Ashby and Heather wards told us that not all staff were caring or respectful. One patient on Heather ward claimed that they had previously watched a staff member walking past a distressed patient and did not seek to reassure them or ask what was wrong.

We spoke with five patients on long stay or rehabilitation wards; they told us they felt very well supported, and staff and were kind, caring, and respectful. One patient told us there wasn't enough to do at the Willows. Another patient said on their comment card they did not see enough of the occupational therapist.

We spoke with nine patient families and carers. Some families and carers told us that the service was not responsive, telephone calls to the service were not returned. Not all families and carers knew they could attend virtual ward meetings and care programme approach meetings. Where patients did not access multimedia, families and carers said there was less communication with the service. Some families' carers said that the meals were unhealthy.

One family member told us their relative could be challenging but they felt they were well cared for. Another relative said their relative was a "changed person" since going to the Willows and they were able to go home last Christmas. A family member spoke about enjoying regular meetings in the service gardens with their relative. Families and carers said the wards were clean.

One patient at Stewart House told us other patients made comments around their protected characteristics and staff had not care planned the needs of the patient.

The trust also collected feedback from patients in a variety of ways, including surveys, iPads, community forum meetings and the Friends and Family Test. The trust told us patients across mental health inpatient wards had commented positively about their experience of care. Patients said staff who cared for them were knowledgeable, professional and friendly.

Outstanding practice

We found the following outstanding practice in wards for people with learning disability and or autism:

- The trust had appointed a patients and carers facilitator, whose role was to actively support, promote and encourage patient and carer involvement at all levels of the services. Support for patients and carers included active involvement in care planning, day to running of the service, wider service development, such as the planned short breaks service and recruitment. The post holder also acted as a liaison between all levels of the organisation

Our findings

therefore ensuring the patients' and carers' voice was heard both up and down the information system. The post holder ensured that all information was in an accessible format, and where technology was proving to be a barrier finding creative ways of breaking down these barriers. The impact of this post had been to free up care staff from these lead roles, to focus more on direct patient care.

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:

In response to concerns we found at this inspection, we issued the trust with a warning notice in regard to shared sleeping arrangements and call alarms and told the trust to make significant improvements in these areas. Following inspection, the trust promptly submitted an action plan with details of how they plan to address the concerns raised.

We told the trust that it must take action to bring services into line with seven legal requirements. This action related to three services.

Trust wide

- The trust must ensure it immediately reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. (Regulation 10(1)).
- The trust must ensure that patients are able to summon for staff assistance effectively in all wards, to include communal areas and dormitories. (Regulation 12(1)).

Long stay or rehabilitation wards for adults of working age

- The trust must ensure environmental risks are identified and mitigated against including checks of the communal garden at Stewart House. (Regulation 15(1)(2)(a)(b)).
- The trust must ensure there are effective systems and processes in place to audit risk assessments across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a)).
- The trust must ensure there are effective systems and processes in place to audit care plans across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a)).
- The trust must ensure at the Willows staff consistently apply and record appropriate contemporaneous records for seclusion. (Regulation 17(1)(2)(c)).
- The trust must ensure that the privacy and dignity is protected around the respectful storage of patient's clothes; (Regulation 10(1)).
- The trust must ensure protected characteristic needs are identified, care planned and actioned. (Regulation 10(1)).
- The trust must use patient feedback to make improvements of the quality and variety of food available. (Regulation 17(1)(2)(a)(e)).
- The trust must ensure staff are up to date with mandatory training including Mental Health Act training. (Regulation 18(1)).

Our findings

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

- The trust must ensure it immediately reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. (Regulation 10(1)).
- The trust must ensure that the privacy and dignity of patients is always maintained. (Regulation 10(2)).
- Staff must ensure they routinely explain rights to informal patients, offer written information and record this. (Regulation 11(1)).
- The trust must ensure that patients are able to summon for staff assistance effectively in all wards, to include communal areas and dormitories. (Regulation 12(1)).
- The trust must ensure that all wards are properly maintained with requests being attended to in a timely way. (Regulation 15(1)).
- The trust must ensure that managers review incidents in a timely way, in line with trust policy. (Regulation 17(1)).
- The trust must ensure the acute and psychiatric intensive care wards have consistent and effective management of contraband items – to include lighters. (Regulation 17(1)(2)).
- The trust must ensure that all patients have appropriate access to a range of psychological therapies. (Regulation 18(1)).
- The trust must ensure that all clinical staff receive training in the Mental Health Act which is updated regularly. (Regulation 18(2)).
- The trust must ensure that all clinical staff receive training in the Mental Capacity Act which is updated regularly. (Regulation 18 (2)).
- The trust must ensure that all clinical staff are trained in basic life support, and qualified nurses undertake intermediate life support training. (Regulation 18(2)).

Wards for people with a learning disability or autism

- The trust must ensure that all staff follow NICE guidance regarding the use of rapid tranquilisation and monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. To protect patients from the risks of over sedation and possible loss of consciousness. (Regulation 12(2)(f)).
- The trust must ensure that all staff are trained in basic life support and intermediate life support. (Regulation 18(2)(a)).
- The trust must ensure there are effective systems and processes to monitor the quality of clinical records, in particular seclusion records and physical health monitoring post rapid tranquilisation. (Regulation 17(2)(b)).

Action the trust SHOULD take to improve:

We told the trust that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Trust wide

Our findings

- The trust should continue to keep under review, the governance arrangements described in the memorandum of understanding to ensure that they continue to reflect the benefits of joint working including the wider benefits of emergent provider collaboratives.
- The trust should continue to keep under review, the medium-term financial strategy in context of the Integrated Care System that is informed by productivity and efficiency opportunities; workforce planning; and service change.
- The trust should ensure that national guidance is followed when completing disclosure and barring checks for staff.
- The trust should ensure that patients receive copies of clinicians' reports in advance of hospital managers' hearings.
- The trust should continue to review their processes to accurately report how local and statutory requirements for duty of candour are met.

Long stay or rehabilitation wards for adults of working age

- The trust should consider at Stewart House, minutes of community meetings are completed with action staff have taken in response to patient feedback (Regulation 17(1)).
- The trust should consider a review of the patients' welcome pack to include diversity and inclusion matters. (Regulation 10(1)).

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

- The trust should ensure that all staff treat patients with dignity and respect at all times. (Regulation 13(1)(2)).
- The trust should ensure that lessons learnt from incidents are shared with staff across the acute and psychiatric intensive care wards. (Regulation 17(21)).
- The trust should continue to work towards reducing the number of prone restraints. (Regulation 12 (1)).
- The trust should ensure that staff work collaboratively with patients to produce care plans, copies of which should are offered and documented (Regulation 9 (1)).
- The trust should consider risk assessing each patient to determine if giving a locker key to patients is appropriate which enables them to freely access items in lockable storage. (Regulation 9 (1)).
- The trust should ensure that all clinical staff have appropriate training to ensure they can access patients care plans and risk assessments easily. (Regulation 18 (2)).
- The trust should ensure that Mental Health Act documentation is scrutinised upon receipt by competent staff, and any issues acted upon. (Regulation 17 (1)).

Wards for people with a learning disability or autism

- The trust should ensure all staff have access to and feel confident using the electronic patient record systems. (Regulation 17 (1)).
- The trust should consider how to meet patients' needs for evening and weekend activities in a meaningful way. (Regulation 9 (1)).

Is this organisation well-led?

Our rating of well-led improved. We rated it as requires improvement because:

Our findings

Leadership

The leadership team had capacity, capability, skills, knowledge and experience to perform their roles. They had a good understanding of the services they had responsibility for.

Following our last inspection in 2018, most members of the previous leadership team had left or retired from the trust, with new posts put into the structure leading to a new executive team. The previous leadership team produced an action plan and made improvements to most, but not all requirements when we revisited in June 2019.

In July 2019, the new trust board formed a buddy relationship with a mental health and community health service NHS trust in Northamptonshire (Northamptonshire Healthcare NHS Foundation Trust – NHFT) following the previous inspections in 2018 and 2019. A new chief executive was appointed as a shared role between the two trusts. This allowed collaborative working, targeted support on a range of initiatives including staff programmes, quality improvement and strategic planning. The buddy relationship lasted for two years. In this time the new trust board formulated plans to address the remaining requirements from the previous inspections.

A formal group working agreement was established with Northamptonshire Healthcare NHS Foundation Trust, supported and agreed with NHS England and NHS Improvement which started in April 2021. This arrangement allowed shared learning and collaboration to continue from the foundations of the buddy scheme.

The new chief executive had built a strong executive team and had developed a supportive and collaborative culture within the trust board. The trust board shared four executive directors and had committees in common with Northamptonshire Healthcare NHS Foundation Trust. A deputy chief executive was appointed in April 2021. Financial leadership on the board had been strengthened with the appointment of a chief finance officer (CFO), shared with Northamptonshire Healthcare NHS Foundation Trust. The division of responsibilities between the CFO and interim finance director were clearly and consistently articulated.

Following the appointment of a new chief executive a new trust board was formed. We noted how much time the new executive team had invested in making and implementing improvements during the COVID-19 pandemic.

Leadership behaviours had been developed, were embedded and had a strong presence in the board and amongst senior leaders. Leadership training had been developed and continued through the pandemic with 200 staff involved. Middle managers understood the challenges of the trust and board members supported them to submit plans for innovation and service development.

There was a culture of inclusive, compassionate and effective leadership with plans to sustain the progress made. The trust had recognised the need to further develop plans to address career progression for staff from a black, Asian and minority ethnic (BAME) background into senior positions in the organisation. There was 13 black, Asian and minority ethnic staff in senior positions. The trust had made a commitment to secure 40 black, Asian and minority ethnic staff into leadership positions but this was dependent on continued investment in the leadership programme. A talent management programme was in place across the trust to home grow the workforce. A programme called ‘WeNurture’ continued to grow and have a strong presence to coach, mentor and develop staff to progress to higher graded roles. The appraisal system was used to identify those who had a desire and potential to develop. Governance structures and training plans were in place to support this process.

The non-executive directors told us there was now confidence and change in the leadership of the trust and that transformation had taken place in governance and system working. However, whilst there was challenge to the board

from the non-executive directors, there was scope for increased and more dynamic and direct challenge with follow up questioning until complete assurance was received on trust performance and risk. We observed there was a missed opportunity to hold some board members to account on issues such as safer staffing at the private board meeting where further challenge and scrutiny could have satisfied areas of concern.

Reverse mentoring had been further developed in the trust. The first cohort of staff who started the programme concluded in January 2020 and a second cohort commenced in November 2020. A total of 82 staff were involved.

Fit and proper person checks were in place for all board members and non-executive directors. However, we found that recommendations from national guidance (The Lampard report 2015, recommendation 7) were not in place to complete disclosure and barring checks every three years.

A people plan 2021 to 2023 was in place with the aim to demonstrate dedication to create an inclusive culture, further develop a workforce plan and offer opportunity for development. Each objective had a timeframe and was linked to 'bricks' of the trust's strategy Step Up to Great. The people plan showed how progress would be reviewed in committees that sat within the trust's governance structure.

There was a positive approach to authentic leadership with approachable leaders. A values-based recruitment process was in place and embedded. Consideration had been given to succession planning and ensuring board resilience. Inclusive recruitment was in place to ensure recruitment panels were made up of a diverse staff group.

Senior managers and heads of service said executives and non-executive directors were approachable, visible and easy to talk to. Some staff told us in our core service inspection, they did not know who some board members were and had not seen them in acute wards for adults of working age services. However, the trust told us they had taken action to follow national guidance to reduce face to face contact during the COVID-19 pandemic. The trust ensured a safety-first approach in line with infection prevention and control guidelines. Other methods of communication were used to deliver key messages from senior leaders, such as blogs, social media messages, newsletters, monthly team brief sessions, weekly video messages from the chief executive and question and answer sessions by executive and non-executive team members.

Vision and strategy

The trust had developed a credible strategy and clear vision with robust plans to deliver high quality sustainable care to people. The leadership team knew and understood the provider's vision and values and how they applied to the direction of the trust.

The trust had made significant improvements to develop a strengthened vision and strategy. The Step Up to Great strategy identified key priority areas of focus which were linked to the trust's vision.

The new trust strategy was underpinned by a refreshed and improved governance structure. Nine 'bricks' of the strategy created a foundation on which all staff engaged in leadership behaviours and values which, in turn, aimed to achieve the trust's vision. The leadership behaviours and values were fundamental to how staff delivered care and worked with each other. The trust engaged and collaborated with the buddy trust, Northamptonshire Healthcare NHS Foundation Trust, a relationship which was well developed and had opportunity to continue to develop with a new group working arrangement. The leadership team described they were invested in a continued and developing culture of continuous learning, which the buddy relationship with Northamptonshire Healthcare NHS Foundation Trust had created.

Our findings

The vision and strategy were now joined up, clear and accessible to all staff and had been developed with input from staff and those who used services. Board development sessions were used to engage the board in strategy design and used to regularly review objectives. Every member of the leadership team interviewed knew their role in delivering the strategy and the contribution their teams made to achieving the objectives.

The strategy was aligned with the local health economy and took into account the needs of the developing Integrated Care System (ICS). The trust created a health inequalities framework, shared with three health and wellbeing boards in the health and social care system.

Heads of departments described a number of plans which coordinated with the trust strategy, for example, the people plan, equality diversity and inclusion strategy, research and development strategy (2021-2023) and a workforce plan. There were a number of priorities the trust had immediate focus on which contributed to achieving the vision. This included eliminating dormitories, patient safety strategy, facilities management plan and a mental health transformation plan. Although work had started on the eradication of dormitories, and was a significant milestone for the trust, and given concerns had been raised in several past inspections, progress was disappointingly slow. We saw at the Bradgate Mental Health Unit that patients continued to live in shared accommodation, and we saw examples where this impacted on the quality of life and dignity of some patents. On some wards, the estate was tired and did not foster a recovery focus.

The trust held 'big conversation' events to gain feedback from staff on what worked well and the challenges during the COVID-19 pandemic. The trust designed a recovery road map with a theme of three Rs: reflect, reset, rebuild. Staff identified seven themes of focus. These included, maintaining health and wellbeing support, have a blended approach to working from home or a work base, and ensure buildings and IT are fit for purpose. Staff also identified the trust should continue to embed leadership behaviours, and keep innovative ways used during the pandemic to meet the needs of those who use services.

Culture

The trust had developed a culture that nurtured staff who worked for the trust. Staff at all levels felt respected, supported and valued. The trust promoted equality and diversity in daily work and provided opportunities for development and career progression. The trust leadership team were committed to deliver an extensive health and well-being offer to staff.

The group working arrangement with Northamptonshire Healthcare NHS Foundation Trust building on buddying relationships, gave access to partners who understood the need to balance safe clinical care with financial control and delivery, but without compromise for patient safety. The development of the East Midlands Alliance meant that three trusts were developing as centre of expertise.

The new trust board used role modelling and leadership behaviours embedded within the strategy to demonstrate a positive and open culture. This had been embedded throughout most of the organisation. Senior leaders and heads of departments were clearly values driven. However, in some of the services we inspected, we heard of some occasions where staff did not demonstrate behaviours the trust expected when caring for those who used services.

The organisational development team had responsibility to deliver on the people plan with a leadership development programme. A golden thread of valuing people, valuing difference through a peer support programme was in place. This included mandated diversity in recruitment panels, staff engagement through surveys, an extensive health and wellbeing offer, flexible working arrangements, listening conversations and events and acting against racism and

discrimination. The people plan was clear how such objectives would be realised and measured within clear timeframes. The reverse mentoring programme included seven leaders from the trust's, two of which were heads of nursing from a black, Asian and minority ethnic (BAME) background. The programme was valued and promoted by directors of the trust.

We held focus groups with staff ahead of our inspection. All staff we spoke with told us they felt proud to work for the trust, valued their teams and were proud to make a difference to those who used services. Staff told us they were particularly proud of the dedication staff gave to their work during the COVID-19 pandemic.

The trust continued to provide an extensive range of health and wellbeing offers to staff. Leaders of the trust viewed staff wellbeing as a high priority. Staff praised the trust highly on its wellbeing offer through the COVID-19 pandemic. The trust offered wobble rooms, daily briefings, debriefs, flexible working, IT provision for remote working, risk assessments on personal circumstances and advice on keeping well.

There was an improved safety culture in the organisation. Safety first was a common theme in trust board meetings and committees. Improvements had been made in screening serious incidents, ensuring lessons were learnt from incidents and action plans included embedded evidence to demonstrate learning. Safety was not compromised by finance.

Staff networks were now well established and membership to groups had increased. There was a proactive approach to equality, diversity and inclusion with regular network meetings with an executive member actively involved. Issues from staff networks were escalated to trust board or to a director. Staff networks actively signposted staff to partner groups such as Freedom to Speak up Guardian, human resources and trust listening events. Processes and systems were in place to support staff and we heard that staff had confidence in the changed culture around diversity and inclusion. The equality diversity and inclusion network had revised the Workforce Race and Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) circulated it to board and was included in meaningful appraisals of staff. The WRES and WDES action plans included seven priorities trust wide to continue to build upon. During the COVID-19 pandemic, the trust chief executive made a public statement in regard to the trust's commitment to anti-racism in light of the Black Lives Matter campaign. Staff across the trust had a strong commitment to this value.

The equality diversity and inclusion strategy expired in March 2021, but the working group had collaborated with 20 patient representatives to develop a meaningful future strategy instead of quickly reproducing a replacement. The trust told us the people's council would be included in collaboration with the design of the future strategy. Equality diversity and inclusion was on the operational risk register and this highlighted the action the equality and diversity taskforce had taken to use workshops to establish trust wide priorities for 2021/22.

The trust continued to develop a culture of speaking up. There was a Freedom to Speak up Guardian in post who was supported by 26 Freedom to Speak up Champions and further work was required to advertise for further Champions. The COVID-19 pandemic curtailed many engagement sessions that would have normally taken place. Virtual engagement sessions replaced face to face sessions and Freedom to Speak up Guardians' messages were reinforced. Collaboration with the group working agreement with Northampton Healthcare NHS Foundation Trust, to adopt stronger awareness of speaking up was in place. The most recent staff survey showed 80% of staff felt able to speak up, 1% above the national average. There was an upward trend in the number of staff who contacted the Freedom to Speak up Guardian in 2020 to 2021, with 165, which the trust saw as a healthy culture where staff feel safe to speak up. Work had taken place to encourage staff to speak up with the Freedom to Speak up Guardian and Freedom to Speak up Champions, human resources and trust listening events.

Our findings

The trust applied their statutory duty of candour effectively. There was a clear process in place led by the patient safety team when things went wrong. There was a mortality review group, and a serious incident group. A 'culture of candour' was promoted and in early stages of embedding. Between 06 September 2019 and 06 November 2020 there were 62 serious incidents graded as moderate harm or above which required an apology. The trust offered an apology for 61 of 62 incidents and followed guidance for statutory duty of candour when required. In one case, attempts were made to provide an apology, but an apology could not be sent and clear reasons for this were recorded. In addition, the trust shared with families and carers, when appropriate, their quality improvements and lessons learned as a result of investigations they had completed. At the time of inspection, we reviewed information submitted to trust board in April 2021 and May 2021 which described how the trust had not met their local standard to offer an apology within ten days of an incident of moderate harm and above. Following inspection, the trust had reviewed how it reported performance against local targets for offering an apology when serious incidents occurred and submitted an improved reporting system for compliance with local and statutory duty of candour requirements.

We continued to be assured of trust oversight of complaints. The complaints team had a schedule to monitor timescale of responding to complaints. Data provided by the trust showed the trust received 215 complaints in a 12-month period, reduced from 1240 complaints in a 12-month period (July 2017 to June 2018) at our last inspection. Adult mental health services recorded 121 complaints, family's young people and children, and learning disability services recorded 51 and community health services had 43.

The 2020 NHS staff survey completed by trust staff had a 52% response rate. Areas which showed improvement against previous years scores included health and wellbeing, views on how immediate managers support staff, morale, quality of care, a safe environment (bullying and harassment), a safety culture, and staff engagement. Two areas were above the national average: safe environment – bullying and harassment and safe environment – violence.

The trust had an active volunteer network and celebrated national volunteers' week with a virtual award ceremony to say 'thank you' to all volunteers who gave time to help those who used services.

The trust held celebrating excellence annual awards events. In 2020, the virtual event was held to reward 41 members of staff who had been shortlisted for 13 award categories. Over 200 nominations were received for the 2020 awards.

Governance

The trust leadership team had not ensured that all requirements from the last inspection had been actioned and embedded across all services. In 2018, we identified concerns in care planning, shared sleeping arrangements, environmental cleanliness and maintenance, and provision of relevant therapies in some core services.

Improvements had not been applied and embedded across the whole trust. In 2018, we had concerns at the Bradgate Mental Health Unit about maintenance and shared sleeping accommodation. At this inspection, the concerns remained. Care plans had improved in some services but not across all.

Governance processes operated effectively at board level to ensure that performance and risk that were highlighted were managed well, however, this had not been embedded into all core services and oversight of issues found at the last inspection in 2018 had not been addressed in all areas at this inspection.

There were clear responsibilities, roles and systems of accountability between executive and non executive directors to support good clear governance and management at trust board level.

Our findings

The trust's corporate governance structure had improved. There was clarity in level one, level two and level three committees and the reporting lines into board. Two level two committees (safeguarding and legislative committees) was made up of representatives from divisional teams. Highlight reports played a key role for all committees and were escalated to board and back down into divisional management teams via meetings, with clear agendas and opportunity to provide feedback.

Financial governance was overseen by a director of finance for the trust with overall responsibility. A shared chief financial officer (CFO) was in post through the group working agreement with the buddy trust**.** The trust gave a good account of embedded financial governance at board, committee and divisional management team levels. The additional senior leadership capacity provided by the CFO allowed focus on the development of business cases (including capital) and partnership working both with ICS and provider partners. The changes arising from the introduction of the group working agreement structure were very recent, roles and responsibilities were still settling down.

The trust chair led the ICS finance committee, the interim finance director attended system finance meetings weekly and we observed a range of styles and approaches to governance and assurance between board members, contributing to board effectiveness overall.

The head of internal audit had given significant assurance about the operation of other internal controls reviewed in the trust in 2020-21. There was one audit (procurement) where partial assurance had been given.

There was clarity about the distinctive responsibilities of the CFO and interim director of finance. The interim director of finance had statutory board responsibility for finance and had the principal links with the audit and assurance committee. The CFO led on capital and estates and was seen more as a board advisor. These arrangements had been in place since April 2021.

The governance arrangements under which the divisional management teams operated were clearer since our last inspection. Divisional management teams were supported by appropriate finance, human resources, communications and clinical expertise and had an improved governance structure that gave increased confidence that key risks were reviewed on a monthly timetable.

The trust had renewed effective systems and processes in place relating to the governance of the Mental Health Act (MHA). The trust's executive medical director was the executive lead for the MHA. The senior MHA administrator had day-to-day responsibility and oversight of the MHA within the trust. The trust had MHA collaborative meetings, which took place every two months. These meetings were attended by trust staff and external representatives. The topics discussed in these meetings included MHA activity, MHA related-incidents, training and compliance. The trust had a legislative committee, which met every two months. The committee had oversight of, and monitored, all aspects of MHA performance across the trust. The legislative committee reported to the quality assurance committee, which reported directly to the trust board. The senior MHA administrator was responsible for developing and updating policies about the MHA. They also were consulted about other policies, to ensure their compliance with the MHA. The trust had a MHA procedural document, last reviewed in February 2020, providing a user-friendly guide for staff about the MHA. The MHA training was role-specific and no longer mandatory for all staff. Due to the pandemic, the current training was being delivered remotely. This could have impacted the training compliance levels at core service level. The MHA administration team disseminated information, such as updates relating to the MHA, to trust staff.

The trust had 12 hospital managers (members of a committee authorised to consider the discharge of patients detained under certain sections of the MHA). The hospital managers were appointed following an open recruitment process. The composition of the current hospital managers' team was representative of the diverse local community. The hospital

managers met twice a year. The senior MHA administrator provided periodic updates to the hospital managers, for example, in relation to changes in legislation. The hospital managers spoke highly of the support they received from the MHA administration staff. Hospital managers undertook annual appraisals. There was a system in place for hospital managers to provide feedback of any concerns they had.

The trust underwent an audit of its systems and process, conducted by an external auditor. The auditor's annual report for 2020/21 looked at five key areas and gave a view of the trust's position. The external auditor did not identify any significant weakness with regard to the trust's arrangement for ensuring value for money. There were no significant weaknesses identified in financial sustainability, governance or improving economy, efficiency and effectiveness.

Management of risk, issues and performance

The trust board, heads of departments and senior leaders had access to the information they needed to manage risk, issues and performance across the trust.

The new trust board had developed a comprehensive organisational risk register (ORR) that identified risks to the organisation, gave each risk a current score, a residual score and applied a target score which the board were tasked to achieve. The ORR was a significant improvement from the previous inspection and the trust had a safety culture for which the board was held to account by the non-executive directors, and other (non-voting) members of the board. The audit and assurance committee effectively reviewed the ORR. The risk scores were reported in the context of the board's risks with controls, assurances, both internal and external, evidence used to demonstrate action or risk, gaps and actions with time frames, which set out how the trust intended to achieve a target risk.

The trust could now articulate the plans they had to further develop the ORR and move to a more developed, mature and improved risk overview. Senior leaders told us that risk was a language that was now developed in the organisation and staff understood their roles and responsibilities and accountabilities. Staff at ward level knew how to escalate risks to their divisional team, and in turn this could be escalated to board level through appropriate committees and the improved governance structure.

The ORR was scrutinised at the strategic executive board on a monthly basis. Deep dives were undertaken at a range of governance forums including at the Quality Forum and at the Quality Assurance Committee. Each of the level two committees reviewed their slice of the ORR for which they were responsible. Level three committees have oversight of operational risks. The flow of risk review took place in a joined-up way between all committees. Highlight reports at all levels of the organisation fed into the appropriate committees. The risk review group which met monthly supported regular reviews and gave validation of operational risk. Each service line and directorate governance meetings considered risk, quality and performance information alongside the risk registers for their relevant areas.

An external auditor found the ORR to be sufficiently detailed to effectively manage key risks.

A risk and assurance lead had recently been appointed with an aim to strengthen assurances throughout the organisation, to ensure that policy was followed, and controls and audits of actions were scrutinised further. This was an area for further development.

The trust delivered training to all levels of staff in the organisation to help understanding of the ORR.

The trust told us about its estate's risks. It was planning to bring hard and soft facilities management in-house, but progress had been slower than it had hoped due to the necessity for all NHS trusts to change their priorities and respond to the COVID-19 pandemic. This risk was being escalated through the operational risk register. There had been progress

on capital investment to raise the standards of its inpatient accommodation; and improve services to children and young people through the Beacon Unit. The trust had been successful in attracting approved funding under the governments Modernising the NHS Mental Health Estate programme, announced in July and October 2020. The capital funding was being invested in eradicating dormitory accommodation.

One issue from the 2018 inspection that had not been addressed by the previous leadership team, in a timely way, was to eradicate shared sleeping arrangements. This meant the new leadership team needed to formulate extensive plans to address the concerns, and in this time the COVID-19 pandemic hit, and priorities changed. The new executive leadership team felt passionate to deliver on plans to eradicate dormitories, however, progress was slow. The shared sleeping arrangements remained at this inspection, but it was recognised the time delay that occurred between the previous leadership team and the new, and the impact of the COVID-19 pandemic on making significant progress. Patients on four wards at the Bradgate Mental Health Unit and wards at the Evington Centre and Bennion Centre, had shared sleeping accommodation (dormitories). However, the new executive team completed business cases and financial action plans to address as quickly as possible the shared sleeping arrangements whilst managing admissions into the clinical areas and safely managing COVID-19 cases simultaneously.

The new executive leadership team had agreed a plan with four phases to the environmental changes, with wards undergoing structural changes to create single occupancy rooms, ward by ward. At the time of our inspection, phase one where Bosworth ward at Bradgate Mental Health Unit had been completed. Phase two was programmed to commence in October 2021 (Ashby and Aston wards). However, we were not assured engagement with staff and patients of Bradgate Mental Health Unit had taken place at all stages. Staff in these services could not tell us what the plan entailed, just that the dormitory accommodation was being removed. The remaining two phases included two wards at The Evington Centre, (commencing December 2021) and three wards at the Bennion Centre (commencing August 2022). Monthly progress meetings took place and as of the review meeting in June 2021, the programme was behind timescales for phase two.

The trust told us, part of the programme of works to eradicate dormitories as part of the 'therapeutic inpatient workstream' and involved those who used services to give views. This part of the programme followed once all major structural changes had been made and was focused on the aesthetics of environments. One workstream of this programme was 'safe and inviting ward environments' but was in early stages to form a business case for re-provision of the Bradgate Mental Health Unit in three years' time.

Following inspection, the trust submitted an action plan to address privacy and dignity issues in shared sleeping accommodation. This included provision of additional storage solutions, arrangements for improved laundry access to decrease dirty laundry storage in bedroom areas, and additional store room space where patients could keep belongings. The trust developed a new privacy and dignity environmental checklist and coproduced activities to help patients develop strategies to manage their environment. A privacy and dignity audit was planned to take place in September 2021.

The most significant risk facing the ICS and therefore the trust was financial sustainability. The trust was actively engaged in ICS development and financial planning at system level but had not yet developed its own medium-term financial plan. There was a risk that the levels of recurrent savings expected of the trust over the four-year planning period will exceed the ambition of its current plans. The trust had recognised system financial risk as being beyond its risk appetite**.**

Our findings

The trust had also attracted £9.25m for its Child and Adolescent Mental Health Service and eating disorder inpatient unit in Leicester. In addition, it will receive capital cover of approximately £9.8m from the ICS capital allocation for backlog maintenance and IT spend.

The trust had met its financial targets for 2020 to 2021. An external auditor had reviewed and signed off trust accounts for the same period. One significant risk was identified in relation to the processes for ensuring financial sustainability. In response to this, the auditor considered the outturn position of the trust and the ICS and noted appropriate actions to mitigate the position. There was evidence of collaborative working between the trust and ICS partners. The ICS financial plan was submitted to NHS England on 6 May 2021 following appropriate review and approval, in accordance with the relevant guidance from NHS England. The trust followed NHS planning guidance by working within the ICS. The 2021/22 system plan showed a breakeven position and included efficiency targets of £3.7m of which £1m was the trust's share, which due to timing were yet to be fully identified, however were being worked on. The ICS provided a clear summary of key challenges underpinning the plan for the first half of the financial year (H1), and a number of programmes were being considered across the system to respond to these challenges, demonstrating that the system had begun to respond to the identified challenges.

Internal auditors gave significant assurance in regard to operation of internal controls. Plans for the budget for 2021 to 2022 had been consolidated into the ICS.

The trust benchmarked its financial performance using Model Hospital cost data and other data. Divisional management teams focused on financial and workforce sustainability giving dedicated time monthly. The trust had recently established a transformation committee to replace the former cost improvement plans outcomes committee. However, improved financial sustainability will require not only increases in productivity and efficiency but also transformation of services.

The trust now had improved systems in place to identify learning from incidents, complaints and safeguarding alerts. Since the permanent appointment to the director of nursing role in November 2020, new appointments had been made to restructure the patient safety and compliance team. This included an associate director for allied health professionals and compliance, a lead for assurance and compliance, and a head of compliance. The head of safety had clear accountability to director level. There was now a culture of safety within the organisation which had been promoted through learning events, big conversations, emails and newsletters. The trust submitted reports to external stakeholders, including statutory notifications to the Care Quality Commission (CQC). The trust had completed work to improve and standardise templates on which serious incidents were reported based on themes and trends of reported such as falls, and self-harm, patient incidents and non-patient incidents. There was ongoing work to devise templates for other forms of incidents, such as violence and aggression. However, the quality of some serious incident notifications to the CQC varied. In the past 12 months, some notifications were submitted with missing sections, and anomalies in the final report. From 1 January 2020 to 31 December 2020 32% of serious incident reports notified to CQC were over two months late and 68% were reported within the timescales. 36 incidents were reported more than two months late with the highest number of days being 729 days since date of incident and the least being reported two days of the incident. However, with ongoing feedback to the trust during engagement meetings, this was a steadily improving picture.

Final action plans which identified learning and action to be taken following an incident, now contained embedded evidence to demonstrate how learning was completed and shared with teams. However, during our core service inspections, we found that not all ward teams heard about learning from incidents which had occurred in other areas of the organisation, but just those which had occurred within their own teams.

Our findings

During staff focus groups, staff told us that there were not enough investigators to conduct the serious incident investigations. Other staff told us there was not adequate time and resources allocated to staff acting as investigators. A recruitment process had just been completed to appoint eight patient safety investigators. This would allow senior clinicians who would have usually carried out serious incident investigations to carry out their clinical role rather than take time out to complete investigations into serious incidents. There were plans to develop the safety team further with clear roles and responsibilities.

Safer staffing was a risk on the ORR that scored in the highest category. The trust board were cited on the risk of safe staffing levels in services to keep patients safe. The board received safe staffing reports monthly and the trust completed six monthly establishment reviews or workforce planning. Weekly staffing meetings took place in services and hot spot areas for staffing were escalated to the director of nursing with actions to mitigate risk. Appropriate actions and plans were in place to mitigate the overall risk.

Risks during the COVID-19 pandemic were well managed. An incident coordination centre was established and met on a regular basis, at times daily, to review briefings, and how the trust and the system should respond to the frequently changing picture in a coordinated way. The incident coordination centre was held in collaboration with other trust's in the system and continued at the time of inspection, with a plan to continue until needed. Infection prevention control (IPC) measures were in place, and an NHS Improvement board assurance framework was completed to give the board assurance of its response to the pandemic. The trust's Infection Prevention and Control assurances were rated as amber by NHS Improvement in 2020 and was due to be reviewed in August 2021 but was rescheduled for a later date. The trust implemented a specific financial regime during the pandemic, and external auditors did not identify any significant financial weaknesses relating to governance during the pandemic. The trust developed new ways of working and designed clinical care around national restrictions that were mandated, to control the spread of the pandemic. New services and wards were set up when needed to meet surges in demand. Face to face contact was minimised where possible and technology used to see those who needed services, such a texting services for young people, WhatsApp, and Microsoft Teams consultations. There was co-production by members of the service user / carer network for a mental health and wellbeing workbook, to support people during the pandemic. The trust provided 'wobble' rooms where staff could seek support and discuss issues with colleagues. Leaders told us they were humbled by the dedication staff had shown to caring for their patients during the pandemic. Leaders said they were immensely proud of what staff had achieved during a most challenging time.

Information management

The trust effectively collected and analysed appropriate and accurate information about outcomes and performance. Information was challenged and acted on in a robust way.

The trust engaged actively with other local health and social care partners to ensure that an integrated health and social care system was commissioned and provided to meet the needs of the local population.

The board received information on quality and sustainability. Committees and divisional team meetings used agendas aligned to the Step Up to Great strategy bricks, to address quality and sustainability at all levels across the trust, within a new, strengthened governance system. Divisional teams used dashboards effectively to report against key performance indicators. Highlight reports were used consistently to escalate issues or report on progress from divisional management teams to board. Non-executive directors told us that statistical process charts (SPC) were now regularly available to review data and performance of services and gave them grip and understanding of measuring progress. Challenge on information received by committees was still maturing. Opportunity for non-executive directors to bring robust and detailed challenge to directors was modest, in particular around safer staffing issues.

Our findings

Staff at all levels of the organisation had access to information technology equipment and systems needed to do their work. Staff focus groups told us how responsive the trust had been in ensuring staff had the right technology to meet patient need and continue services during the COVID-19 pandemic. The trust was highly praised by staff for being responsive to need at this time.

An electronic clinical notes system had been introduced to the trust in November 2020, which allowed staff to have access to patient records across the whole health and social care system. The roll out of the project, which started in 2018, was overseen by the information management and technology operational committee and included a quality improvement team who monitored the rollout. Super users were identified to deliver training and support staff in clinical areas once the system went live. However, there were issues with some staff who did not have access to this in some services we inspected, and some staff said they needed additional support to navigate the system effectively.

The trust used benchmark and comparative information to assess productivity and efficiency.

The audit committee functioned effectively with a non-executive director as chair with membership from directors, and external audit partners. The committee moved from a focus on clinical audit to embracing all aspects of quality improvement across the trust.

The MHA hospital managers said whilst the hospital managers' hearings were held remotely during the pandemic, these had not been the easiest for patients and panel members but were the only reasonable option they had. Some hospital managers had experienced difficulties with the technology. Additionally, some hospital managers thought the trust could have offered a little more help and support for patients with the technology, particularly when they were dialing into community treatment order (CTO) hearings from their homes. The hospital managers were unaware of any future plans of the format of the managers' hearings, for example, if they would return to face to face hearings.

The hospital managers raised concerns about the patients' access to reports prior to a hearing taking place. We were told that clinicians did not always share reports with the patients in advance of the hearings. This is not in line with the MHA Code of Practice. The hospital managers told us this issue had been raised prior to the pandemic and more recently. The hospital managers also told us that sometimes the nurse or responsible clinician attending the hearing did not know the patient. They gave us an example where the patient did not know the nurse attending, who was a bank nurse.

The trust rolled out a new computer programme called Autoplanner, in community district nursing services to optimise travel time between patients' homes, the services they needed, and the skill required by the clinician who visited. It also calculated the availability of staff to carry out the contact. Staff in focus groups told us it helped in their day to be more effective in their roles.

Information about how the trust worked was available to the public in a way that could be easily understood. and accessible. The trust provided a statement at the inspection to explain how they met the accessible information standard. Information that need to be shared in an accessible way for all, was assessed on a case by case basis. An easy read descriptor of the role of the trust board was available.

Engagement

The trust ensured that people who used services, the public, staff and external partners were engaged and involved in the design of services.

Our findings

The board was deeply engaged with the integrated care System (ICS) developments of Leicester, Leicestershire and Rutland (LLR). Executive directors held portfolios that were embedded with ICS plans to develop the local health and social care system. The trust had significant engagement with the emerging mental health provider collaborative.

The trust led in collaboration with system partners, to develop transformation of health and social care systems in LLR. The trust had established ICS design groups to review pathways of care as part of the ICS partnership board. The trust also engaged with other trust's in an emergent East Midlands Alliance / mental health trust provider collaborative. Within the Alliance three mental health trust's had clear roles and responsibilities to take the lead on a care pathway with Leicestershire Partnership NHS Trust taking the lead on adult eating disorder services. Divisional directors gave a clear account of what they were trying to achieve. The trust led the NHS and local authority transforming care partnership collaborative team and the trust's / CCG collaborative mental health team. The trust also played a role as a joint executive group in strategy meetings of the ICS for finance, quality, people and medical.

The trust led on the workforce bureau for COVID-19 vaccination staff, where the trust worked as a system partner and provided three vaccination sites during the pandemic.

Engagement of staff, those who used services and stakeholders had improved since our last inspection. We saw various examples of how the trust had involved others in the design of new services and when seeking and acting on feedback received about existing services. The patient experience and involvement team had developed a delivery plan which set out plans and objectives to ensure the trust listened and responded to the needs of those who use services. Virtual meetings continued through the pandemic, and membership doubled.

Staff and those who used services had been involved in the design of capital schemes. Staff buy-in to carrying on with the changed working practices arising from trust's response to the pandemic, underpinned the first half year efficiency and productivity plans. A productivity and efficiency task and finish group consulted with staff and volunteers.

The trust had recruited change champions in May 2019, who worked to engage staff across the organisation in the redesign of the Step Up to Great strategy. The co-designed vision was established in October 2019, which was followed by co-designed leadership behaviours in January 2020. Listening events and 'big conversations' took place across the organisation to deliver the new vision and strategy.

The trust WRES action plan was co-designed with staff following a number of focus groups.

A people's council, an independent advisory body for the trust had been established in September 2020 with 15 members from those who used services, carers and stakeholders from the local voluntary and community organisations and groups. The people's council had developed a 'WeImprove' plan to help shape the trust's approach to engagement and review the experience of those who use or have been in contact with services provided by the trust.

A Step Up to Great mental health transformation plan had been launched for public consultation, led by the local clinical commissioning group (CCG), with strong involvement from the trust's mental health services, to reshape provision of mental health services in the health and social care system. Stakeholders were engaged with the trust; communication and engagement with key stakeholders had improved, such as Healthwatch, CCGs, Youth Advisory Board and partners within the ICS.

Co-production took place when projects were identified for service improvements. The building of a new inpatient unit for children and adolescents with mental health problems incorporated the views of young people. Recovery and collaborative care planning cafes existed where patients and staff come together to have collaborative conversations

about care planning and recovery. The cafes had links with the Recovery College which delivered courses to patients and staff. Service improvements in learning disability services emerged from a talk and listen group; a moving on booklet was created by the eating disorder team in collaboration with young people from the unit; and staff and patients at the Agnes Unit set up a 'My Voice' project, which designed an easy format agenda for patients to share their views at the start of meetings. A Mental Health and Wellbeing Workbook was co-production to make a workbook available to the public to support people through mental health challenges of the COVID-19 pandemic.

Results from a survey conducted with stakeholders in 2020, showed a positive response on their views of the trust. The survey results were collated from 85 responses, from 43 organisations (61 online responses and 24 interviews). Results demonstrated 76% knew about the Step Up to Great strategy and respondents viewed the trust's strengths as being open and having a strong influence in the health and social care system.

The trust used initiatives during the COVID-19 pandemic to support those with mental health difficulties so they could access the right help at the right time. A signposting resource was developed in 11 languages which shared information on different local services that could be directly accessed. Audio versions and downloadable leaflets were available.

Learning, continuous improvement and innovation

The trust had embedded systems and process for learning, continuous improvement and innovation.

The trust board had formed a buddy relationship with Northamptonshire Healthcare NHS Foundation Trust, shortly after the previous inspection in 2018. A formal group working agreement was in place, supported and agreed with NHS England and NHS Improvement which started in April 2021. This arrangement has allowed shared learning and collaboration to continue.

The trust had four shared director positions on the board, including the chief executive. There were deputy positions in place for many executive directors and head of departments. During the buddy relationship period, senior leaders of the trust worked alongside their counterparts at Northamptonshire Healthcare NHS Foundation Trust and shared learning on how to improve governance, redesign services, and develop and grow a renewed vision and strategy. As the relationship developed, overtime, both trusts shared a vision of collaborative learning, a two-way process.

The divisional management teams evidenced clear buy-in by staff and volunteers to change working practices in a post-COVID world. Changes had been consulted upon and were being implemented.

The trust used learning from their experience during the COVID-19 pandemic, to redevelop crisis pathways and reduce significantly adult acute out of area placements.

The trust had developed an improved and coordinated approach to quality improvement. The trust had moved away from a 'self-regulation' approach, where projects and ideas were led by individual departments and were not overseen or coordinated by the board, resulting in a scattered approach to continuous improvement. Instead, the trust had developed a 'WeimproveQ', a trust wide quality improvements framework, with six key principles for driving improvements with projects initiated by staff and or teams.

During the COVID-19 pandemic, the trust set up an urgent mental health care hub and central access point, which provided urgent mental health supports to people of all ages in Leicester, Leicestershire and Rutland.

Our findings

Staff participated in research and the trust was proud to report its role in delivering research-based projects. There were a number of established research projects and some new studies. As part of the National Institute for Health Research (NIHR) contracts, the trust submitted two research papers in 2020. The trust contributed to the one in three campaign, (research into depression); the trust made a significant contribution to 'Urgent Public Health' COVID-19 research programme; received a grant with a local university for research in the use of artificial intelligence for learning disability; part of the data collection scheme for research into acute respiratory and emerging infection consortium (ISARIC); the GLAD study to explore risk factors in those who have experienced anxiety and or depression. The research and development newsletter featured research stars of the month, where staff were nominated for a trust award for their contribution to research and development. Research forums and workshops were held regularly, and learning events were promoted for staff to attend.

The trust had been recognised as finalists in the annual patient experience network awards (PEN) 2021. The recovery and collaborative care planning cafes were shortlisted in the strengthening foundation award; the mental health and wellbeing workbook was shortlisted for the support for care givers award. In December 2020, the trust invited carers and those who used services to nominate staff and volunteers for a COVID hero award to recognise those who showed dedication and commitment to the trust's vision and values. The Health Service Journal awards shortlisted the trust for two awards in February 2020. They included The NHS workplace Equality Award for the trust's work to become Champions of Race Equality and the Partnership of the Year Award for the implementation of Autoplanner within district nursing. In addition, the trust's CEO was named by HSJ as one of the top 100 NHS CEOs in the country. The Autoplanner computer functionality also won the Best Use of a Solution category in the Smarter Working Lives 2020 awards, in December 2020. It was also shortlisted in the nursing times awards and runner up in the Health Tech Newspaper's Excellence in Implementation category.

In May 2021, the trust launched a director of nursing fellowship programme to support band five nurses to develop clinical excellence, clinical academic awareness and skills.

In 2019, the eating disorder service at the trust continued to receive accreditation from the Quality Network for Eating Disorders (QED) to the Royal College of Psychiatrists accreditation programme for eating disorders, which involved assessment against approximately 300 standards.

The trust received a grant from NHS Charities Together in June 2021, (as part of a local partnership of three local NHS charities) to develop healthcare for the most vulnerable people in the community, following the Covid-19 pandemic. The trust were one of seven successful charities to receive the grant from 40 who applied for funding.

The trust collaborated with the local authority and commissioners to lead on new ways of working for the care of older people in the LLR system. The trust was one of seven areas chosen to be a regional accelerator for the Ageing Well Scheme.

The Beacon Unit, a purpose-built inpatient unit for children and adolescents with mental health problems, opened in November 2020. The trust was able to secure donations from the local system who fundraised for specialist sensory and sporting equipment to enhance inpatient care.

Various initiatives and projects were successfully delivered by staff at the trust; these included a 'hug in a mug' campaign which distributed mugs of soup to staff since the start of the pandemic; the 'Knead to chat' campaign which

Our findings

won a national patient experience award to help patients tackle mental health challenges, and develop a social network using the art of breadmaking; an art exhibition created by offenders at HMP Leicester and HMP Stoken; a breastfeeding support programme between the trusts 0 to 19 service collaborated with Leicester Mammas for families in Leicester – five health visitors were nominated for champions awards in recognition of the support they gave to families.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Oct 2021	Requires Improvement →← Oct 2021	Good →← Oct 2021	Requires Improvement →← Oct 2021	Requires Improvement ↑ Oct 2021	Requires Improvement →← Oct 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Oct 2021	Requires Improvement ➔➔ Oct 2021	Good ➔➔ Oct 2021	Requires Improvement ➔➔ Oct 2021	Requires Improvement ↑ Oct 2021	Requires Improvement ➔➔ Oct 2021

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ➔➔ Oct 2021	Requires Improvement ➔➔ Oct 2021	Requires Improvement ➔➔ Oct 2021	Requires Improvement ➔➔ Oct 2021	Requires Improvement ↑ Oct 2021	Requires Improvement ↑ Oct 2021
Child and adolescent mental health wards	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Community-based mental health services for older people	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Community mental health services for people with a learning disability or autism	Good Feb 2017	Good Feb 2017	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017
Forensic inpatient or secure wards	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Mental health crisis services and health-based places of safety	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Requires improvement Apr 2018	Requires improvement Apr 2018
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement ↑ Oct 2021	Requires Improvement ↑ Oct 2021	Requires Improvement ➔➔ Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement ↑ Oct 2021	Requires Improvement ↑ Oct 2021
Wards for older people with mental health problems	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Wards for people with a learning disability or autism	Requires Improvement ➔➔ Oct 2021	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires Improvement ➔➔ Oct 2021	Requires Improvement ➔➔ Oct 2021
Community-based mental health services of adults of working age	Requires improvement Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Requires improvement Apr 2018
Specialist community mental health services for children and young people	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Inadequate Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires improvement Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Requires improvement Feb 2017	Requires improvement Feb 2017
Community end of life care	Good Feb 2017	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Community health services for children and young people	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Community health services for adults	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018
Overall	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Wards for people with a learning disability or autism

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they found.

Staff could see patients in all parts of the wards.

The ward followed guidance on eliminating mixed sex accommodation.

There were no potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Although two staff said they had not received training to use the ligature cutters safely, other staff said this training had been part of their induction and orientation to the ward.

Staff had easy access to alarms and where risk assessments allowed, patients had easy access to nurse call systems. Where a patient did not have a call alarm this was because they were in constant observation of staff already.

Maintenance, cleanliness and infection control

Ward areas were clean, well kept, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing. Staff were compliant with COVID-19 infection prevention and control measures following trust policy and procedure.

Seclusion room

While the seclusion room met the requirements of the Mental Health Act code of practice, observation of patients was hindered by the size of the viewing window. The provider had installed CCTV with monitors in a separate room away from the de-escalation area. Shower and toilet facilities were available in a separate room within the de-escalation area. A clock was available but staff had removed this to the sluice room at the request of the patient who was using the room at the time.

Wards for people with a learning disability or autism

We looked at four seclusion records. One record did not have a time when the doctor visited but did have the doctors name and confirmation of the review taking place. Two records did not have the time a doctor visited but did confirm the doctors name and because each seclusion was less than an hour, they did not break the code of practice. The fourth record (three-hour seclusion) gave the time but not the name of the doctor. None of these omissions impacted on the patient's care whilst in seclusion.

Clinic room and equipment

Staff ensured clinic rooms were fully equipped, resuscitation equipment was accessible and tested and they checked emergency drugs regularly.

Staff checked, maintained, and cleaned all clinical equipment.

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.

Nursing staff

The service had high vacancy rates for registered nurses. They had 5.0 whole time equivalent (WTE) vacancies from an establishment of 13.5 WTE registered nurses. These vacancies were backfilled by block booked agency staff known to the service and patients.

The service had no healthcare support worker vacancies.

While the service had high rates of registered bank and agency staff managers requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers could adjust staffing levels according to the needs of the patients. They explained that since February 2021 they had increased staffing levels to meet increased patient acuity. Minimum safe staffing for the unit was 10 staff on early shifts and seven staff on night shifts. Managers had increased the numbers to 20 staff on early shifts and 17 staff on night shifts. These levels were reviewed daily.

The service had reducing turnover rates. The turnover rate for the last six months was 6%.

Managers supported staff who needed time off for ill health.

Sickness levels for registered nurses had reduced from 8% between December 2020 and February 2021 to 1% in May 2021. Sickness levels for healthcare workers was 10% from December 2020 to May 2021.

Patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled. The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

At the time of inspection, the manager's dashboard showed low compliance in moving and handling, 62%, PREVENT 48%, *immediate life support* 64%, *basic life support* 50%, management of actual or potential aggression 62% and risk assessment training 73%. The trust told us that training compliance had been affected by the Covid 19 pandemic. On the 01 April 2020 this service was compliant at 87% for intermediate life support training and was at 83% for basic life support training. At the start of the pandemic face to face training stopped for 3 months from April 2020 to 06 July 2020 for substantive and bank staff. All staff were given 6 month refresher extensions for mandatory training in line with national expectations. In addition, the trust's intermediate life support training and management of actual or potential aggression training compliance rule for all bank staff was removed to enable more support for clinical services. When training resumed training course capacity reduced by 50% to 75% due to Covid 19 restrictions.

Following inspection the trust provided data for this core service stating an overall compliance figure of 86%, with individual courses as follows: 91% for moving and handling, 93% for safeguarding children and adults level one, 89% for safeguarding adults level two and 81% for safeguarding children level two, 75% for management of actual or potential aggression holding skills and 100% for management of actual or potential aggression disengagement skills, 56% for *basic life support* and 64% for *immediate life support*. As the service uses seclusion, restraint and occasional rapid tranquilisation having all staff trained in either *Immediate life support* or *Basic life support* is considered an essential requirement.

Managers told us the trust was playing catch up with the face to face training due to COVID-19 restrictions. Staff confirmed this in the focus groups we held with staff. The trust told us that staff who delivered training had been redeployed into services during the pandemic which resulted in a stop to face to face training for a short period. The managers' dashboard showed that all staff who were out of date had training dates booked over the next eight weeks. The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers checked mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery.

Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.

The ward staff took part in the provider's restrictive interventions reduction programme.

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.

Staff used the risk assessment tool on their electronic recording system.

Wards for people with a learning disability or autism

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could see patients in all areas of the unit and followed procedures to minimise risks where they could not easily see patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were reducing. Staff took part in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

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.

Staff kept up to date with their safeguarding training. At the time of inspection, the manager of the service told us compliance with safeguarding training was 69%. Following inspection, the trust provided data to show compliance with safeguarding children training and adults level one was at 93%, 89% for safeguarding adults level two and 81% for safeguarding children level two.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

We could not be assured that all staff had easy access to all SystmOne information.

Wards for people with a learning disability or autism

Managers could not authorise some agency staff to access the electronic system because they had not completed the required training. Some permanent staff had not completed training to use the system or did not feel confident to use it because the online training had not suited them. Some learning disability templates, such as care plans, were not compatible with SystmOne and were being redesigned.

Managers had started to use paper records that administrators scanned to the electronic system, to mitigate the problem with access to essential information. Managers realised this could result in a backlog and delays logging rapidly changing information and to overcome this problem they had produced a patient folder for each patient located on the wards. This folder held the patient's key information including a 'this is me' sheet, current risk assessment, current PBS plan daily activity timetable and key care plans.

When patients transferred to a new team, there were no delays in staff accessing their records.

Staff stored records securely.

Medicines management

The trust did not follow NICE guidelines for the use of rapid tranquilisation medications. Staff included the instructions for the use of medications prescribed to be given only when needed, the time interval to leave between doses and the maximum dose allowed to be given in 24 hours. The service did use systems and processes to administer, record and store medications. Staff knew about and worked towards achieving the aims of STOMP (stopping over-medications of people with a learning disability, autism or both).

Staff used rapid tranquilisation extremely rarely and there was only two episodes in four months to review during our inspection. However, staff did not follow NICE guidance for monitoring the side effects following the use of rapid tranquillisation. Staff were unable to demonstrate how they monitored the side effects and the patient's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Staff were not able to show they were completing these checks to protect patients from risk of over sedation and possible loss of consciousness.

As required medications was used sparingly in the service, only three patients on the wards were prescribed 'as required' medications. Staff included the instructions for the use of 'as required' medications, in relation to the time interval between doses and the maximum dose allowed to be given in 24 hours to protect patients from over sedation. Staff recorded this in the electronic clinical notes system. Audits had been completed to show staff had correctly recorded this information.

Staff reviewed patients' medications regularly and provided specific advice to patients and carers about their medications.

Staff stored and managed medications and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medications.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medications safely.

Decision making processes were in place to ensure staff did not control people's behaviour by excessive and inappropriate use of medications.

Wards for people with a learning disability or autism

The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well, and staff recognised incidents when they occurred. 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.

One staff member told us they did not think all incidents that occurred were being reported on the incident reporting database because staff did not always have access to the system or did not feel confident using the system. However, we did not find any evidence to demonstrate this.

We saw how managers had fully investigated the event, upheld duty of candour, identified and put into practice lessons learned. Managers shared learning about never events with their staff and across the trust. Managers shared learning with their staff about never events that happened elsewhere. Managers and staff were aware of the Learning from Deaths Mortality Review Programme (LeDER). Managers and staff supported the review process and made changes from any learning shared.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff and patients after serious incidents. Psychology staff supported the team with debriefs following incidents. Data supplied showed that 21 debriefs had taken place between March and May 2021, using a new debriefing tool that when completed managers placed on the staff members personal record. However, one staff member said they had not had a formal debrief after a serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, through service bulletins and learning boards. Staff met to discuss the feedback and look at improvements to patient care at team meetings internal and external governance meetings.

There was evidence that managers had made changes because of feedback. Examples included temporarily increasing staffing to meet increasing patient acuity since January 2021, opening all wards for patient care to allow patients more space and flexibility, increasing supervision and training for temporary staff, appointing a dedicated patient and carer facilitator to actively promote and encourage more patient and carer input into the day to day running of the Agnes unit.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Wards for people with a learning disability or autism

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Leaders had addressed all previous requirement notices.

Leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Leadership was strong and the clinical services manager, clinical lead and matron worked well together to support the ward manager. Staff told us they had respect for these managers, the changes they had and were making and the support they gave to staff daily. Managers focused on staff recruitment and retention, staff wellbeing, engaging patients and carers, identifying a pathway through the service to encompass some short break placements, and ensuring all staff were using positive behavioural support (PBS) plans.

Staff who attended a focus group told us there had been lots of contact with the associate director, and senior staff had based themselves in the service. The Director of Nursing had been to visit staff on the ward on a number of occasions.

Vision and strategy

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

Culture

Staff felt respected, supported and valued. Most staff said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

However, therapy team absence meant that evening and weekend activity programmes were suspended. While healthcare support workers (HCSW's) were supposed to support the therapy program they often did not do this. HCSW's felt it was not their role to do this and did not feel confident enough to follow through on plans when patients declined the activity.

We heard how there are some nursing staff who have been in post at the Agnes unit for a long time and were reluctant to embrace change. The impact was that new initiatives either took a long time to become embedded or did not get started. Managers were aware of this and explained some of the things they had put in place to address the issues and bring people on board.

Staff who attended a focus group told us the team in the service had won a valued star award from the trust. Staff told us they were proud to work in the service and had made improvements in safeguarding.

Governance

While the service had systems and processes in place to audit medication administration, the audit had not identified that staff had not recorded any physical monitoring checks of patients after the administration of rapid tranquilisation. Although we saw that rapid tranquilisation was only administered twice in the last four months in this service.

Audits of seclusion records had not identified gaps in recordings of doctor arrival times.

With exception of rapid tranqulisation medication audits and audits of seclusion records we saw other databases, audits and action plans that showed governance systems and process were robust. Managers used the governance systems to identify issues and produced action plans to address the issues. Examples included staffing, mandatory training, introduction of bespoke PBS training and opening and allocating teams of staff to all five wards for patient use to accommodate those patients who needed low stimulation areas. Management of risk, issues and performance.

Wards for people with a learning disability or autism

Although teams had access to the information, they needed to provide safe and effective care and used that information to good effect, managers recognised that there were some issues with the newly introduced electronic database. Four staff we spoke with did not feel confident or sufficiently trained and supported to use the electronic system. Managers explained how they had put in place plans to mitigate the impact of these issues on patient care until the trust rectified the problems. Such as formalising the use of some paper based key patient information.

Information management

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

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

Managers from the service were active in the work of the local transforming care partnership.

Engagement

Staff who attended a focus group told us a discharge coordinator role had been in place since June 2020. This role helped to improve discharges of patients into the community and made links with local commissioners.

Learning, continuous improvement and innovation

In August 2020, the service completed a quality improvement project to address some concerns in the service linked to safeguarding and safety. A local buddy trust completed an independent review of the service and made recommendations for improvement. The quality improvement plan was supported by senior leaders of the trust. Staff who attended a focus group told us the quality improvement plan had really helped the service to make improvements in care delivery particularly around safeguarding patients, strengthening incident reviews, risk assessments and an improved handover process.

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

Requires Improvement ↑

Is the service safe?

Inadequate →←

Our rating of safe stayed the same. We rated it as inadequate because:

Safe and clean environment

Not all wards were safe, clean, well-furnished or well maintained.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Staff could observe patients in most parts of the wards. Staff followed procedures to minimise risks where they could not easily observe patients. This was an improvement from the last inspection.

The ward complied with guidance around mixed sex accommodation. Mixed wards had separate male and female areas.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms, but patients did not. Not all patients could summon help from staff if required. There was no patient alarm access in some ward areas, including the dormitories. Ward staff had wrist bands available they could allocate to patients to summon help, but these were still in original wrappers and stored in the nursing office on Watermead ward. Staff did not routinely give these out or offer to all patients. Staff had not completed risk assessments or care plans for those patients who required a wrist band. Patients would have to shout to call for urgent attention in some areas across the service.

Following inspection, the trust submitted an action plan which reviewed patient access to call alarms. The action plan included purchase of additional alarms which meant every patient had access to a call alarm if required. The trust also reviewed all patient risk assessments to identify an appropriate call alarm system required dependent on risk and need. The trust put in place a standard operating procedure for use of call alarms. The action plan also included access to alarm systems for visitors.

We revisited some wards following our inspection. We found one bed area with the patient's personal items stored in brown bags. Staff told us the patient had packed ready for discharge. This was a potential fire risk, in particular as there was not an effective process in place for staff to manage the number of lighters on the wards. Following inspection, the trust submitted an action plan to provide more storage. We saw some patients had lighters in their possession on four wards.

The previous trust leadership team had not responded in a timely way to eliminate shared sleeping arrangements (dormitories) following our previous inspection in 2018. Most members of the previous leadership team stepped down after the previous inspection, which led to a new executive team that came into post. There was also a change in divisional leadership level of this service, with a new director who came into post in September 2019. This meant that at the end of 2019, the new leadership team needed to formulate extensive plans to address the concerns, and in this time the pandemic of COVID-19 hit and affected the trusts' timeframes to address issues. On four wards, there were shared

sleeping arrangements for patients. Bosworth, Thornton, Ashby and Aston had dormitories. The maximum number of patients who shared a bedroom ranged from two to four. The trust was told to address the arrangements for eliminating dormitories at our previous inspection in 2018. There were four phases to the eradication of dormitories programme. Phase one – Bosworth and Thornton wards. Phase two – Ashby and Aston wards. Notes from the estates and medical equipment committee showed that in March 2021, approval was given for the business case for works which was submitted in October / November 2020. Works had commenced on dormitory rooms on Bosworth on 29 March 2021 with a date of completion by 2 July 2021. A progress report dated 1 June 2021 showed work on Thornton ward was due to start on 19 July 2021 with planned completion date of 22 October 2021.

In a monthly progress report dated 11 June 2021 submitted to the trust by a property consultant overseeing works, it stated a planning application for works was submitted on 1 April 2021 for phase two of works on Aston ward. Work had not started on Aston ward. A monthly report in June 2021, of progress to board on the eradication of dormitories programme reported the programme was behind timescales for phase two.

Following inspection, the trust submitted an action plan to address privacy and dignity issues in shared sleeping accommodation. This included provision of additional storage solutions, arrangements for improved laundry access to decrease dirty laundry storage in bedroom areas, and additional store room space where patients could keep belongings. The trust developed a new privacy and dignity environmental checklist and coproduced activities to help patients develop strategies to manage their environment. A privacy and dignity audit was due to take place in September 2021.

Maintenance, cleanliness and infection control

Not all wards were safe, clean, well-furnished or well maintained. Maintenance teams did not consistently undertake repairs in a timely way. Staff told us maintenance repairs and requests could take a while to be actioned. A staff member on Ashby ward said that they had ongoing problems with the toilets and bathrooms “for months”. Requests to unblock toilets, change light bulbs, make repairs to ward furniture and attend to problems with electricity supply and room temperature had frequently taken days to be resolved.

On inspection during the ward tours, we saw areas which required repair or items required replacing. Staff told us that all of the issues we observed had been reported. We were unable to cross reference this with maintenance requests, as folders on the wards had not been kept up to date. Staff explained that maintenance issues could be phoned through and reported or emailed. Staff did not consistently accurately record how they had reported maintenance issues. On Watermead, we found a broken window in the male bathroom; the TV cabinet in the communal lounge was broken; dirty and torn sofa in the TV room; the door stop by the female communal toilet was broken. On Thornton ward, one call bell point had been smashed and exposed loose wires and had been sounding for several hours before it was fixed. On Aston ward, the patient phone was broken. On Ashby ward, the patient phone was broken. On Beaumont ward, the television was not fixed to the wall as the ward were awaiting a cabinet; the ward office was very hot despite having fans. The thermometer recorded a temperature of 26 degrees. Staff had reported the issue and were struggling to work in the heat. On Heather ward, patients said that there was not enough ventilation on the wards. The matron opened some vault windows via a remote. They later told us that this had been an ongoing concern for around five years. On Belvoir ward, some furniture was torn.

The trust provided information on maintenance requests over the last six months. There was a total of 439 requests made for repairs or maintenance issues between 1 December 2020 to 26 May 2021. There were 147 issues outstanding or recorded as incomplete. The time taken for maintenance repairs was an issue highlighted at our inspection in 2018. All

maintenance was delivered by an external provider, a local acute trust and executive leaders had decided to produce a business case to take back control of maintenance. The trust board had approved the plan and it was in very early stages of starting at the time of our inspection. The trust said this would improve responsiveness of maintenance in the service and across the trust estate.

Staff maintained cleaning records to ensure the premises were clean. Most of these were up to date. We observed some bathroom and toilets which were not clean.

Staff followed infection control policy, including handwashing.

Seclusion rooms

Seclusion rooms allowed clear observation and two-way communication. Clocks were visible from the rooms. Toilet facilities were close by but were not accessible from the seclusion rooms. This meant that if a patient was too unwell to leave the seclusion room, staff would give them a disposable urinal or bedpan to use in the seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment regularly.

Safe Staffing

The service did not always have enough regular nursing staff who knew the patients well. Not all staff were up to date with mandatory training.

Nursing staff

There was not always enough regular nursing staff on duty to meet patient needs and the service used high numbers of bank and agency staff. There had been occasions where staff had not facilitated escorted leave due to staffing. Two patients told us they had experienced cancelled leave, and numerous staff confirmed that facilitating escorted leave had been difficult at times which had led to either a cancellation, or where possible delayed leave.

Qualified nurses found it difficult to have one to one time with allocated patients as they frequently got called away, although did try frequently to facilitate this. The trust submitted data following the inspection to show they had carried out a review of incidents and collated patient feedback in May 2021 which did not identify any staffing impact on the quality and safety of patient care.

Each ward had qualified nurse vacancies, which amounted to almost 28 vacant posts across the service. Managers had recruited additional healthcare assistants on some wards to ensure safe staffing numbers. Bank and agency usage had varied over the past six months. Agency usage on the acute wards ranged between 303 and 631 shifts per month, with bank shifts ranging between 654 and 1202 per month. On the psychiatric intensive care wards, agency usage had ranged between 55 and 252 shifts per month, with bank shifts ranging between 112 and 254. Across the acute and psychiatric intensive care wards, there had been 278 shifts which had not been filled by bank or agency staff between November 2020 and April 2021.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

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

Managers calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. Managers could adjust staffing levels according to the needs of the patients. If one patient was placed on enhanced observations, staff from the ward numbers would facilitate this. Staff covered further enhanced observations with additional staff.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough day and night medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Not all staff were up to date with basic life support and intermediate life support training. During interviews, numerous staff told us that they needed to complete or update in this area. Training compliance was below 75% in four of the wards across the service: Thornton was 67%; Beaumont was 62%; Belvoir was 65% and Griffin was 38%. Training compliance for intermediate life support was low on three wards: Watermead 45%; Griffin at 58% and Heather ward at 61%. Senior staff told us that training staff had been redeployed during the pandemic and face to face training had stopped for a short time. All face to face training was being reintroduced following the COVID-19 pandemic with staff being invited to attend mandatory training on a clinical risk basis and contacted directly by the learning and development team to attend. Following inspection, the trust told us that training compliance had been affected by the Covid 19 pandemic. On the 01 April 2020 this service was compliant at 84% with all mandatory training except for two wards who fell below compliance for management of actual or potential violence and aggression holding skills. At the start of the pandemic face to face training stopped for 3 months from April 2020 to 06 July 2020 for substantive and bank staff. All staff were given 6 month refresher extensions for mandatory training in line with national expectations. In addition, the trust's intermediate life support and management of actual or potential violence and aggression training compliance rule for all bank staff was removed to enable more support for clinical services. When training resumed training course capacity reduced by 50% to 75% due to the Covid 19 restrictions.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and Managing risks to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Assessment of patient risk

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after any incident.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

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

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff did not always follow trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff on the acute wards were not consistent with searching patients upon return from unescorted leave. Some patients had managed to take lighters onto the acute wards. Staff from four different wards – Watermead; Aston; Heather and Ashby told us that there had been recent incidents whereby patients had managed to bring lighters onto the wards. This was an issue highlighted at our inspection in 2018. The service did not have a system in place to monitor the number of lighters each ward held.

Use of restrictive interventions

Staff provided lockable space with allocated patient lockers which were out in communal areas of the wards. Staff did not allow patients to have the keys, so patients had to request staff to unlock these each time they wanted to access their secured belongings.

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. However, staff had used prone restraint (chest down) across the service. Between November 2020 and April 2021 staff had restrained twenty patients in the prone position. The majority of these (16) were to administer rapid tranquillisation or to exit seclusion and had ranged between one and five minutes. On Griffin ward staff restrained one patient in the prone position for 10 minutes so that staff could undertake a medical investigation. On two occasions, the police had restrained two patients while in seclusion in the prone position. The trust sent us information around these incidents which demonstrated the restraints had been a last resort and were for clinical reasons. The service had purchased five safety pods. The trust was planning to trial these to reduce prone restraints. A safety pod is a specially designed bean bag which enables physical restraint to be used in a safer way. At the time of inspection staff were awaiting training in the use of these.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff provided lockable space with allocated patient lockers which were out in communal areas of the wards. Staff did not allow patients to have the keys, so patients had to request staff to unlock these each time they wanted to access their secured belongings.

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.

However, three patients told us of times when staff had been rude, threatening and disrespectful towards them. We were made aware that two safeguarding referrals had been made on one ward following concerns around staff behaviour. Both of these staff members had been agency staff who were not working on the wards at the time of inspection, pending investigation. Appropriate policies on management of staff performance had been followed.

We reviewed nine patient's seclusion records. In one record, we noted that a doctor had reviewed the patient at 9.30pm and recommended that the patients seclusion continue throughout the night. Nursing staff wrote in one entry that the patient was “lacking insight or remorse”. We were concerned about this language used, as this could indicate staff were using seclusion as a punishment. Following the inspection, the medical director reviewed this case and reviewed how findings of seclusion reviews should be reflected in records.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff had access to clinical information, although some healthcare assistants told us that despite having received training, they found it hard to navigate patient clinical records.

Patient notes were comprehensive, and all staff could access them.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

Medicine management in this service had improved since our previous inspection. The service used systems and processes to safely prescribe, administer, record and store medications. Staff regularly reviewed the effects of medications on each patient’s mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medications.

Staff reviewed patients' medications regularly and provided specific advice to patients and carers about their medications.

Staff stored and managed medications and prescribing documents in line with the provider’s policy.

Staff followed current national practice to check patients had the correct medications.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medications safely.

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

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medications.

Staff reviewed the effects of each patient's medications on their physical health according to NICE guidance.

Track record of safety

The service had a good track record on safety.

Reporting incidents and learning when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. However, incident reports were not reviewed by managers in a timely way.

Staff did not always get to hear about incidents which had occurred on other wards across the acute and psychiatric intensive care wards. A range of staff we interviewed across the service told us that they did not get to hear of learning from incidents from other acute or psychiatric intensive care wards and could not relay recent learning from incidents. This was an issue highlighted at our inspection in 2018. Staff did get to hear about incidents which occurred on the wards they worked on as ward matrons relayed information to them during handovers and team meetings. Senior staff attended regular incident meetings, but information had not been cascaded successfully to all staff on all wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident and investigated incidents thoroughly.

Managers did not always review incidents in a timely way. Between March 2021 and up until the time of inspection, staff had reported a total of 4,990 incidents across the service. Of these 1,653 were awaiting management sign off. Managers had not signed off two incidents which had occurred in August and November 2020 on Watermead ward.

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same. We rated it as requires improvement because:

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 personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

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

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients. They 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.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Skilled staff to deliver care

The ward teams had access to a range of specialists required to meet the needs of patients on the wards. However, patients did not have a full therapy timetable available to them.

The service had three vacant occupational therapy posts. Within the psychology team, there was one clinical psychologist who worked across the service. Vacancies consisted of two psychologists and three psychology assistants. The clinical psychologist in post held regular reflective practice meetings with staff, undertook de-briefs following incidents, delivered a weekly patient recovery group, attended MDT meetings and offered psychology assessments. Access to psychological services was an issue highlighted at our inspection in 2018.

Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported clinical and non-clinical staff through regular, constructive appraisals of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Most managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. 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.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Not all staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff did not routinely tell informal patients of their rights. We spoke with five informal patients who were unaware of what they could and could not do as an informal patient. One patient told us they did not know they could leave the ward to seek medical attention. Beaumont ward did not have a poster displayed around informal patients and rights as a patient had ripped it down. Staff later replaced this during the inspection. Heather ward and Ashby ward did not have any written information available for informal patients. We returned to some wards following inspection and saw that the trust had fixed signs at the exits to the ward, to tell informal patients they could leave the ward.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff explained to each detained 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.

Staff made sure wherever possible that patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

We reviewed 16 Mental Health Act records and found 10 of these to be in order. In six records we found administrative issues. These issues did not amount to invalid detention. However, we were concerned that these had not been identified during the receipt and scrutiny process. The Mental Health Act administrator assured us actions would be taken to remedy.

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

Not all staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. Healthcare assistants and activity staff we spoke with found it difficult to relay information around the Mental Health Act. Not all staff were up to date with the mandatory training about the Mental Health Act. Compliance with this training in May 2021 was under 75% across four wards: Watermead at 45%; Beaumont at 57%; Aston at 64% and Griffin at 33%.

Following inspection, the trust told us that training compliance had been affected by the Covid 19 pandemic. On the 01 April 2020 this service was compliant at 84% with all mandatory training except for two wards who fell below compliance for Mental Health Act training. At the start of the pandemic face to face training stopped for 3 months from April 2020 to 06 July 2020 for substantive and bank staff. All staff were given 6 month refresher extensions for mandatory training in line with national expectations. When training resumed training course capacity reduced by 50% to 75% due to the Covid 19 restrictions.

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. Healthcare assistants and activity staff had difficulty in relaying information around the Mental Capacity Act.

Some staff could not recall what their training had consisted of. Compliance with the mandatory training on the Mental Capacity Act was below 75% on five of the wards; Watermead at 70%; Beaumont at 69%; Belvoir at 67%; Griffin at 73% and Ashby at 65%.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and DOLS.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

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.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

Is the service caring?

Requires Improvement 

Our rating of caring stayed the same. We rated it as requires improvement because:

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

Kindness, privacy, dignity, respect, compassion and support

Staff were not always caring and respectful towards patients.

Two patients we interviewed on Ashby and Heather wards told us that staff did not always knock on their bedroom doors before entering. One patient on Thornton ward told us that while staff did knock, they did not wait for a response before entering, which had resulted in staff walking into their room while they were changing their clothes, compromising their privacy and dignity. This patient also disliked the fact that the curtain around their bed (in a dormitory) did not draw fully, leaving a gap. We returned to some of the wards following inspection and found that signs had been put on bedroom doors to remind staff to knock and wait for a response before entering. These signs were in place on some of the wards we revisited but not all.

Staff did not always maintain privacy for patients effectively. We noted that nine bedroom windows on Beaumont and Heather wards had no curtains or blinds. Staff assured us that these had been reported and were expecting these to be replaced although did not know how long this would take.

One patient told us that staff had been rude, threatening and disrespectful towards them, which a relative also confirmed. One ward matron told us that a patient had recently alleged that a staff member had assaulted them. Ward matrons were looking into these alleged incidents.

One patient on Watermead ward told us that a staff member had ignored them when they had asked them for a sandwich.

Six further patients across Beaumont, Ashby and Heather wards told us that not all staff were caring or respectful. One patient on Heather ward claimed that they had previously watched a staff member walking past a distressed patient and did not seek to reassure them or ask what was wrong.

Staff had made two recent safeguarding referrals on one ward following concerns around staff behaviour. Both staff members had been agency staff who were not working on the wards at the time of inspection, pending investigation.

We reviewed nine patient's seclusion records. In one record, we noted the language used was not caring or respectful of the patient’s presentation.

Patients generally felt that staff were helpful, but always busy. Some patients said that while staff would help them with their requests, they could be waiting some time due to them being busy with other tasks.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients with care planning, although staff did not give patients a copy of these to refer to.

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff made sure patients could access advocacy services easily.

Involvement of family and carers

Staff informed and involved families and carers appropriately. Staff gave feedback with the patient's consent. Many family members had attended multi-disciplinary meetings by video conferencing.

Staff encouraged families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Bed occupancy across the wards was over 85%. Occupancy on Heather, Thornton and Griffin ward had been over 100% within the last six months. Some leave beds had been used to admit patients to wards, to keep patients in their local area.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The service had no out-of-area placements. There had been only one out of area placement over 14 months. This was a significant improvement since our previous inspection which reported 171 out of area placements lasting between two and 192 days.

Managers and staff worked to make sure they did not discharge patients before they were ready. Staff did not move or discharge patients at night or very early in the morning.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

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

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. Managers monitored the number of delayed discharges and worked with external agencies to try to minimise these. At the time of inspection there were four delayed discharges which all related to a lack of suitable accommodation or ongoing placement.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity.

The trust did not comply with guidance to eliminate shared sleeping arrangements (dormitories). Refurbishment to eradicate dormitories was ongoing across the acute wards and had been slow to progress to make improvements which promoted recovery. Not all patients had their own rooms with ensuite facilities. Some patients slept in dormitories and had to share toilet and bathroom facilities.

Some bedrooms viewed were not personalised. Patients had basic facilities in rooms only, a bed and a cupboard and drawers to store clothing. Some single rooms had a toilet and a hand basin. There were few personal items belonging to the patients, such as photographs. We revisited some wards following our inspection. We found one bed area with all personal items stored in brown bags. Staff told us the patient had packed ready for discharge. Most bedrooms we saw had one storage cupboard with three shelves to store all their possessions to keep them within reach. We saw possessions that were stored on the floor space, and one coat hanging on a coat hanger on the curtain rail surrounding the bed.

Patients had a secure place to store personal possessions, however they were not in the patient's bedroom area. Staff provided lockable space with allocated patient lockers which were out in communal areas of the wards. Staff did not allow patients to have the keys, so patients had to request staff to unlock these each time they wanted to access their secured belongings. Following inspection, the trust submitted an action plan to provide more storage.

The service had a range of rooms and facilities for the patients to enjoy. Wards had quiet rooms, communal lounges, laundry facilities and access to outside space. Wider available facilities included kitchens patients could use, an outdoor gardening area where patients were able to grow fresh produce, as well a gym where patients could exercise. This had improved since our inspection in 2018.

Areas allocated for patient telephones on the acute wards were not private. They were in areas of the wards where other patients and staff could hear conversations. The phones were not enclosed in any way. Patients could use the ward mobile telephones if they wanted privacy and did not have a personal phone.

The service offered a variety of food. The kitchens catered for different dietary requirements upon request. This included Halal food; vegetarian; vegan and foods suitable for those who had food intolerances. Patients were able to access drinks and snacks as and when they wanted. Patients gave different opinions of the food available. Some patients described the food as bland. Other patients said that the food was not very nutritious.

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, and supported patients.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of patients who used the service – including those with protected characteristics.

Staff helped patients with communication, advocacy and cultural and spiritual support. We observed staff speaking with a patient in their preferred language, and patients had received easy access to interpreters or signers as needed. The service had a broad chaplaincy team to meet the different cultural and spiritual needs of patients.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Managers shared the outcome of complaints with their ward teams.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

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

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement because:

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.

A new director of service had been appointed since our previous inspection and knew the service well. There was robust challenge in divisional management meetings and there was collaboration with colleagues and patients in service redesign.

Vision and strategy

Not all staff could relay the provider's vision and values. However, senior staff talked about the trusts continuous journey to improve.

Most staff told us that executive staff members were not visible on the wards. Some had seen some photographs of the executive team, while others said they would not recognise them if they did go onto the wards. Staff did not feel they could approach them. However, senior leaders told us told us they had taken action to follow national guidance to reduce face to face contact during the Covid-19 pandemic. The trust ensured a safety-first approach in line with infection prevention and control guidelines. Other methods of communication were used to deliver key messages from senior leaders, such as blogs, social media messages, newsletters, monthly team brief sessions, weekly video messages from the chief executive and question and answer sessions by executive and non-executive team members.

Culture

Most 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.

Governance

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

Oversight of maintenance was ineffective, with some repairs taking too long to complete. Maintenance logs on the wards had not been updated so staff would not know what jobs had been completed. Some ward areas looked uncared for. Some curtains needed re-hooking; some furniture was broken; some furnishings worn and torn; windows had missing curtains, and some areas required touching up with paint. We highlighted maintenance as an issue at our inspection in 2018. However, the trust board had approved a facilities management workplan that would bring all management of maintenance inhouse and not contracted out to another trust. The plan and it was in very early stages of starting at the time of our inspection. The trust hoped this would improve responsiveness of maintenance in the service and across the trust estate.

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

In 2018 we identified the trust were required to address the shared sleeping arrangements on the wards. Whilst the trust had a plan to eliminate dormitories in a phased way, progress had been slow and one ward, in phase one neared completion since our previous inspection. Phase two was due to start in October 2021, but a monthly review meeting had highlighted a delay to the timescales.

There was no effective system and process for the management of lighters. We found inconsistencies across the acute wards for the safe management of lighters. There were inconsistencies across the wards with the searching of patients when returning from unescorted leave. While staff acknowledged that this should be completed where indicated they admitted that this did not always happen. This had resulted in patients taking lighters and other contraband items onto wards.

Managers met regularly to discuss the learning from incidents service wide. Managers did not successfully cascade information down to all ward staff. Staff we spoke with were unaware of incidents and learning on other wards across this service.

There had been numerous changes in ward matrons on some of the acute wards over the last 12 months. The ward matron on Beaumont had only been in post since March 2021. Ashby ward staff reported having had three different matrons in the last year and told us that the present matron was only temporary. Some nurses within the service had been promoted or found posts elsewhere. Staff reported inconsistencies within the ward teams due to this which they found challenging at times. Some staff reported feeling tired and had worked some shifts without taking adequate breaks because they were too busy.

Management of risks, issues and performance

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

Some healthcare assistants were unaware of how to access care plans and risk assessments. The trust has recently changed their electronic clinical record system. Staff and patients also reported difficulties in some ward areas with poor mobile phone signal and connectivity to the internet. Staff said that connectivity issues had affected the accurate recordings of patient observations at times.

Information management

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

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

Engagement

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

The trust had started a consultation with the public to transform the provision of mental health services. This was led by the local clinical commissioning groups, and senior staff from the service and patients had been heavily involved in collaboration to bring the project to the public consultation stage.

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

Learning, continuous improvement and innovation

The trust board had formed a buddy relationship with a NHFT shortly after the previous inspection in 2018. A formal group working agreement was in place, supported and agreed with NHS England and NHS Improvement which started in April 2021. This arrangement has allowed shared learning and collaboration to continue. The director of mental health services had taken up post from NHFT and had continued the shared learning ethos into acute and psychiatric intensive care services.

A Step Up to Great mental health transformation plan had been launched for public consultation, led by the local clinical commissioning group (CCG), with strong involvement from the trusts' mental health services, to reshape provision of mental health services in the health and social care system.

A speech and language therapy service had been re-established. All new admissions were screened, and the service sees on average 80 patients on the wards. Joint groups were provided with OT and psychology to target communication, social interaction and anger management needs. Ward rounds were adapted on psychiatric intensive care wards to be more accessible to patients with communication issues.

The prayer room and the Bradgate Mental Health Unit was refurbished to be more welcoming and inclusive for users.

In 2019, a gardening competition resulted in funding secured to create an accessible functional multipurpose therapy garden space for patients.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

The service did not carry out safe checks of the outdoor environment at Stewart House. All wards were safe, clean well equipped, well furnished, well maintained.

Safety of the ward layout

Staff completed and regularly updated environmental risk assessments of most wards areas and removed or reduced any risks they identified. However, staff at Stewart House did not carry out checks of the communal garden. We looked at environmental risk assessments, night duty and weekend checks. The garden area was not part of any of the environmental checks. The garden was not well maintained and littered with plates, towels, broken ceramic pots, confectionary wrappers and cigarette ends. The garden was not included on the environmental risk assessment which meant staff did not routinely check this area.

Staff could not observe patients in all parts of the wards due to the layout of the building which was an old building. However, patients were supported with enhanced observations and hourly checks taken as regular practise on all wards.

At Stewart House we saw curved mirrors had been placed in corridors and video camera monitoring gave the staff in the nursing station an overview of all public areas.

The service complied with guidance on eliminating mixed sex accommodation. Stewart House had doors on order to create a fixed separation between male and female areas, but this did not affect any privacy or dignity issues for patients. Female patients were located towards one end of the corridor and male patients towards the other with separate toilet and bathing facilities and gender specific lounges.

There were no potential ligature anchor points on wards in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We saw ligature areas identified on posters in nursing offices.

Staff had easy access to alarms and patients had easy access to nurse call systems in bedrooms, lounges and bathrooms. Some patients had a personal alarm pendant subject to their risk assessment.

Maintenance, cleanliness and infection control

Indoor ward areas were clean and well maintained. Staff carried out regular cleaning and two hourly touch point checks, which included surfaces touched most frequently, door handles and tables. Staff made sure cleaning records were up-to-date and the wards were clean.

Staff followed infection control policy, including handwashing. However, we observed two nurses at Stewart House with face masks drooping over their nose. We did not see staff change masks particularly in handover rooms. There were limited disposal bins for used face masks.

Long stay or rehabilitation mental health wards for working age adults

Seclusion room

Two seclusion rooms at the Willows allowed for clear observation and two-way communication. They had a toilet and a clock. The seclusion rooms were free from hazards and blind spots were mitigated.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.

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.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers told us they had over recruited health care support workers. Managers limited the use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had vacancy rates of 13% for qualified nurses and 23% for healthcare assistants. The service provided vacancy rates data for wards that were closed.

The staffing establishment numbers for staff for from therapy disciplines were 10.39 whole time equivalent (WTE) and vacancies for medics were at 3.70 WTE. The trust did not provide data for the core service vacancy rates. One member of the therapy team told us they had difficulties providing a full range of care and therapy to patients due to staff vacancies. The trust had appointed twice to the occupational therapy post, but candidates did not take up the position.

The core service had reducing rates of bank and agency nurses by the time of inspection. The provider had recorded 1,541 shifts filled by bank staff, 467 shifts filled by agency staff and 163 unfilled shifts in the six months prior to inspection.

Staff had been supported on a phased return to work after time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Safe wards information was placed around the wards.

Patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The service had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was an on-call rota.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Long stay or rehabilitation mental health wards for working age adults

Mandatory training

Most staff had completed and kept up to date with their mandatory training with 92% of staff having completed all mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

All face to face training was being reintroduced following the COVID-19 pandemic with staff being invited to attend mandatory training on a clinical risk basis and contacted directly by the learning and development team to attend. The management of actual potential aggression (MAPA) refresher training had restarted as face to face training.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival, using a recognised tool. However, staff did not regularly update the risk assessments.

Management of patient risk

We reviewed 19 risk assessments across the service. We found six patient risk assessments at the Willows were not regularly reviewed following incidents.

Where risks were identified in some risk assessment there was no corresponding risk management plan in place. One patients risk assessment confirmed they were at risk of falls, but there were no records of management of falls since 2013, and was last reviewed in December 2020. Another patient, admitted in January 2021, was identified to be at risk of harm to themselves upon admission, but there were no risk assessment updates. A third patient had had no risk assessment plans since December 2020, although care plans were in place for self-neglect, and substance misuse. A fourth patient had a risk identified for self-neglect with no risk plans in place. A fifth patient had a m*ulti-agency public protection level three arrangements* in place. The patients' risks assessment identified harm to others but found no risk plan for harm to others or crisis and contingency plans. A sixth patient admitted in May 2021 had no risk assessment in place despite there being two incidents of potential harm on the ward.

The Willows staff were working to improve risk assessment documentation and carried out risk assessment spot checks from August 2019 to March 2021, but improvements were not evident from the risk assessments we sampled.

When we spoke with staff, they knew about any risks to each patient but did not always update the risk assessments.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Long stay or rehabilitation mental health wards for working age adults

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme which met best practice standards.

Staff applied blanket restrictions on patients freedom only when justified.

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.

Most staff understood the Mental Capacity Act definition of restraint and worked within it. Staff followed NICE guidance when using rapid tranquilisation, which was rarely used.

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. Staff kept up to date with their safeguarding training. However, one patient told us other patients made rude comments around their protected characteristics, and staff had not supported them. We found evidence in the patients record that the patient had complained to staff about other patient's comments.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

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

The trust had recently implemented a new electronic clinical record system. Staff at Stewart House had easy access to patients records and were comprehensive.

Staff at the Willows had difficulty navigating the patient electronic systems and could not find documents easily. Staff used a digital device to record patients' physical observations. Staff had difficulties uploading the observation information to the main patients record keeping systems.

When patients transferred to a new team there were no delays in staff accessing their records. Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medications. This was an improvement from our previous inspection in 2018. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medications. Pharmacists provide clinical support to the wards through the remote reviewing of prescriptions. They provide support

to patients who self-administer their own medications. This was provided face to face pre pandemic when it moved to being delivered through video consultations. Clear records were made of patients' allergy status. Patients detained, longer than three months under the Mental Health Act, had appropriate Mental Health Act forms which were available to staff administering the medications. Patients were supported to administer some or all of their own medications where this was appropriate, for example self-injecting insulin and moving through a staged program towards self-administration to support independence and prepare people for when they are discharged.

Staff reviewed patients' medications regularly and provided specific advice to patients and carers about their medications. Pharmacists working from the base pharmacy checked that prescriptions were appropriate for patients but were not part of the multidisciplinary ward team. Doctors talked to patients about any new medications that were being prescribed for them of any changes to their treatments, and nurses reinforced the messages. Information leaflets about medications could be provided for patients to further help their understanding about any medications that they took. There had been little need to administer any rapid tranquilisation recently, but staff were able to describe appropriate processes and checks. Staff had access to the rapid tranquilisation policy and documentation on the wards.

Staff stored and managed medications and prescribing documents in line with the provider's policy. All medications were store securely. The clinical rooms and fridge temperatures were centrally monitored with a system of alerts should the temperature go out of the acceptable range. Controlled drugs were manged effectively. There was a secure electronic system for prescribing medications for patients

Staff followed current national practice to check patients had the correct medications. Medications reconciliation was completed when patients were admitted, and their venous thromboembolism risk assessed. Medications reconciliation was done remotely by the pharmacy team using summary care records but without access to any medications that patients brought in with them.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medications safely. Staff told us that drug alerts were emailed to the ward by pharmacy

Decision making processes were in place to ensure peoples' behaviour was not controlled by excessive and inappropriate use of medications. Prescriptions for medications to control behaviour all included the maximum dose permitted to be given in 24 hours. The electronic prescribing system alerted nurses and prescribers when drugs needed to be reviewed to avoid prolonged use.

Staff reviewed the effects of each patient's medications on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

There had been three serious incidents for this service in the last 12 months. Some staff us about recent serious incidents and how these were being managed and action taken to improve.

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.

Long stay or rehabilitation mental health wards for working age adults

At the Willows we sampled 18 incident reports and found detailed records of incidents were held. Staff reported serious incidents clearly and in line with trust policy. 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 when things went wrong.

Managers and the psychology team debriefed and supported staff after any serious incident. Drop-in support groups were regularly available to all staff

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. However, a doctor with responsibilities for managing patient safety incidents could not remember any serious incidences at the service, although there had been one serious incident in April 2021 that effected a number of patients and staff. The doctor did not recognise this incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received a quarterly bulletin that included findings from a selection of incident investigations, key themes, and implementation and best practise tips. Staff met to discuss the feedback and look at improvements to patient care at staff meetings and staff supervision, where appropriate.

Staff told us managers kept them up to date with progress of investigations following serious incidents. Staff told us that in some cases, that if extra staff were required to manage risks on the ward, managers would provide extra numbers of staff.

Is the service effective?

Requires Improvement  

Our rating of effective improved. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Staff did not always develop and review individual care plans. Not all care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and most were regularly reviewed during their time on the ward.

We sampled eight care plans at Stewart House. Staff had developed collaborative care plans for patients that met their mental and physical health needs. Most care plans were personalised, holistic and recovery orientated. However, one patient with protected characteristics did not have a care plan in place to support their needs. The patient told us they had made a request on admission to supported access to lesbian, gay, bisexual and transgender (LGBTQ+), questioning networks and made the request again six months later.

Some care plans included personal emergency evacuation plans, subject to a risk assessment.

We saw detailed diabetes care plans, weekly psychology interventions and triangle of care plans. The triangle of care describes a therapeutic relationship between the patient, staff member and carer that promotes safety, supports communication and sustains wellbeing. This was an improvement from our previous inspection in 2018.

We sampled 11 care plans at the Willows. Care plans were not of a high standard. Staff did not regularly review and update care plans when patients' needs changed. We found patient updates had been added to old care plans, a lot of entries had been copied and pasted from other care plans and the same information repeated under different headings. Most crisis and contingency care plans were left blank. Some care plans did not correspond with identified risks. We identified at our previous inspection in 2018 that care plans were not personalised or holistic.

We found three care plans had care planning information missing. One patient admitted in May 2021 had identified risks around harm to others with no care plans in place, despite their being two incidents in May 2021 where they had shown a kicking motion to a wheelchair user and exposed themselves to a member of staff. A second patient had a risk identified for self-neglect with no care plan in place. A third patient's risk assessment identified harm to others but found no care plan for harm to others or crisis and contingency plans.

Staff regularly offered patients copies of their care plans.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged 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. The psychological team provide talking therapy outdoors for patients, for example, whilst walking around the hospital grounds, in open spaces.

Staff delivered care in line with best practice and national guidance including a framework for personal recovery from mental illness connectedness, hope and optimism about the future, identity, meaning in life and empowerment. Staff used recovery star, a collaborative tool to support the recovery of adults using mental health services.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes for example: the national early warning score a tool which improves the detection and response to clinical deterioration in adult patients and improves patient outcomes; hospital anxiety and depression scale aims to measure symptoms of anxiety and depression. Staff used health of the nation outcome scale a method of measuring the health and social functioning of people with severe mental illness, and measured behaviour, impairment, symptoms and social functioning.

At the Willows one doctor could not explain the rehabilitation module of recovery at the service.

Staff identified patients' physical health needs and recorded them in their care plans. This had improved since our previous inspection in 2018. Staff made sure patients had access to physical health care, including specialists as required. Patients had weekly access to the physical health nurse at well-being clinics for women and men. A GP attended the wards twice a week.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. One patient had an obesity care plan which included targets and milestones. Staff could refer patients to other professionals as their care needs required. These included dietetics, physiotherapy, speech and language therapist. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service took part in monthly audits for example post falls, falls and assessment and care planning, medicine, nutrition, emergency equipment, cleaning, mattresses management and seclusion checks.

Managers used results from audits to make improvements. In March 2021 psychology staff had evaluated the recovery star tool and are now working towards improved recovery star delivery for patients and staff. The psychologist team reviewed reflective practice groups and now provide regular drop-in reflective practice groups.

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. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Teams consisted of health care support workers, registered nurses, occupational therapists, psychologists, junior doctors and doctors. Stewart House employed an activity coordinator who worked with the therapy team and patients.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported all staff through regular, constructive management and clinical supervision and appraisals of their work. Managers supported permanent all staff to develop through yearly, constructive annual appraisals of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed staff meeting notes and saw staff attended fortnightly staff meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers told us there were lots of opportunities for leadership development with training for example management of ill health, supportive behaviours, we nurture appraisal, and recruitment.

Managers made sure staff received specialist training for their role. Managers provided an enhanced rehabilitation and recovery training programme. This included Recovery star eliciting service users' goals, adverse childhood events, key roles in occupational therapy, introduction to the five P's formulation presenting problem, predisposing factors, precipitating factors, perpetuating factors and protective factor.

Managers recognised poor performance, could identify the reasons and dealt with these.

Long stay or rehabilitation mental health wards for working age adults

Multi-disciplinary and interagency teamwork

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. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The service provided weekly ward round meetings. At Stewart House we observed a patient attend ward round, talked with the multidisciplinary team and ask questions about their medications, cultural needs, discharge plans and talked about their wishes and feelings.

There were regular discharge and care programme approach meetings with patients and family carers. The service had a discharge nurse, social workers that supported the ward teams. The service had effective working relations with the new rehabilitation community transition support team created in response to the pandemic to facilitate faster discharges from the wards.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Ward teams had effective working relationships with other teams in the organisation. The service had links with local authority speech and language therapist and physiotherapists who attended the service regularly.

At Stewart House we observed one staff handover. Staff shared key information to keep patients safe when handing over their care to others.

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

Not all staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Not all staff were up to date with Mental Health Act and Mental Capacity Act training. Compliance for this training was below 75% for some wards. Not all staff kept up to date with mandatory training for the Mental Health Act and the Mental Health Act Code of Practice. Compliance for this training was below 75% for some wards. At the Willows, Acacia ward compliance was 33% and 100% on Maple ward. The trust did not provide a breakdown for Stewart House, Skye and Aaron wards but an overall compliance rate was 72%.

Staff at the Willows had not understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged them well.

On Maple ward at the Willows, there were several issues around one patient's seclusion records, which were incomplete and there was insufficient monitoring. Staff documented a report monitoring the patient every 15 minutes twice after the patient's seclusion commenced. After this, we were unable to find any evidence of staff monitoring the patient every 15 minutes for a period of three hours and ten minutes. We noted the patient transferred to another ward (Belvoir ward) within the trust. On Belvoir ward, we found nine gaps in staff documenting the required 15 minute checks for the same patient.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Long stay or rehabilitation mental health wards for working age adults

The last Mental Health Act monitoring visit for the Willows Maple ward was 2018 and Acacia ward March 2019. The trust provided a statement of action. The only action not met were the locked doors between the female and male areas.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

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.

Staff made 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.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

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 and recorded capacity clearly for patients who might have impaired mental capacity.

Staff kept up to date with training in the Mental Capacity Act. At the Willows, Acacia ward compliance was 93% and 100% on Maple ward. The trust did not provide a breakdown for Stewart House, Skye and Aaron wards but an overall compliance rate was 89%.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Long stay or rehabilitation mental health wards for working age adults

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement 

Our rating of caring stayed the same. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always respect patients' privacy and dignity. Staff treated patients with compassion and kindness They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

At Stewart House one patient's respect and dignity was not upheld. The patient told us other patients made hurtful comments about them in front of staff and felt staff did not support them to resolve the situation.

We spoke with five patients they told us they felt very well supported, and staff and were kind, caring, and respectful. One patient told us there wasn't enough to do at the Willows. Another patient said on their comment card they did not see enough of the occupational therapist. We observed and heard positive interactions between patients and staff across all wards visited. Staff understood and respected the individual needs of each patient. Staff supported patients to understand and manage their own care treatment or condition.

We observed at Stewart House a patient's music group session led by a therapy staff. Staff spoke to patients with sensitivity and encouraged patients to choose a piece of music they would like to listen to on the stereo. Most patients sat and listened to their chosen music and one patient danced.

Staff gave patients help, emotional support and advice when they needed it.

Most staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential.

Involvement of patients

Most staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Long stay or rehabilitation mental health wards for working age adults

Most staff involved patients and gave them access to their care planning and risk assessments. Four patients told us they had been offered psychology but had declined. Staff used this as part of patients care planning My Staying Well and Advanced Statements. An advanced statement is a written statement that sets down patients' preferences, wishes, beliefs and values regarding their future care.

Staff introduced patients to the ward and the services as part of their admission.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients could attend regular community meetings. At Stewart House patient community meeting notes were not completed and did not include the action staff had taken in response to patient feedback. Patients gave feedback around fundraising money overdue for gym equipment, poor meals, outbreak of ants, and not enough activities.

Staff supported patients to make decisions on their care. Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved some but not all families and carers appropriately.

We spoke with nine patient families and carers. Some families and carers told us that the service was not responsive, telephone calls to the service were not returned. Not all families and carers knew they could attend virtual ward meetings and care programme approach meetings. Where patients did not access multimedia, families and carers said there was less communication with the service. Some families' carers said that the meals were unhealthy.

One family member told us their relative could be challenging but they felt they were well cared for. Another relative said their relative was a "changed person" since going to the Willows and they were able to go home last Christmas. A family member spoke about enjoying regular meetings in the service gardens with their relative. Families and carers said the wards were clean.

We saw lots of examples of care planning where the service were working towards better partnership working between the patient, their families and carers. Care planning notes included comments from carers and families. Involvement from families in care of their loved ones was clear in ward round notes.

The trust provided a regular patient experience and involvement newsletter which included opportunities and supporting information for patients and carers.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Long stay or rehabilitation mental health wards for working age adults

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons. Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

The service had no out of area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient.

Bed Management

The provider reported bed occupancy of 93% across this service. Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay was 12 to 18 months. The service had no out of area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care ward always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends.

Discharge and transfers of care

Between November 2020 and April 2021, the service had an average of 59 bed days relating to delayed discharges. The service had monitored and reduced the number of delayed discharges and taken action.

Staff carefully planned patients' discharge and worked closely with the rehabilitation community transition support team for faster discharges. The rehabilitation community transition support team attend the wards for discharge meetings, ward rounds, care programme approach meetings and were known to the patient who were transitioning out of hospital. Managers confirmed most patients go onto their community mental health teams. At the time of our inspection, the rehabilitation community transition support team supported eight patients to prepare for discharge.

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Long stay or rehabilitation mental health wards for working age adults

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity. Each patient had their own bedroom. There were quiet areas for privacy. The food was not always good quality. Patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

At the Willows patient's privacy, dignity were not respected around the storage of their clothes. Patients had access to chest of drawers, shelving in bedrooms and paper bags for storage of clothes, as wardrobes had been removed from bedrooms as a safety risk. We saw one wardrobe that did not look safe and did not have piano style hinges as per national guidance. We saw brown paper bags used in four patient bedrooms. Staff told us brown paper bags were used for storage of clothes. On a return visit to the Willows, we found no further evidence of brown bags being used for storage of belongings, only as waste disposal.

Each patient had their own bedroom, with areas to keep their personal belongings safe. We saw lockers for patients to store their belongings, but these were small and could not store all their belongings. Not all bedrooms included an en-suite shower or bath. Across services bedrooms had a toilet and or a hand basin. Some bedrooms provided full ensuite facilities a shower, toilet and hand basin. There were enough communal bath and shower facilities available.

At the Willows, Sycamore and Cedar wards had closed to be refurbished.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private. Facilities also included activities of daily living kitchen, a computer/art room, a games room, gym rooms and garden areas. At Stewart House we saw a relaxation room set up for light therapy. Several meeting rooms were also available. Gym rooms were also used for staff training, but had not been used for training due to the Covid 19 pandemic restrictions and infection prevention and control guidelines.

Patients told us about the breakfast club in the daily living kitchen, where patients prepared breakfast of their choice and then cleaned up, with the support of therapy staff.

Many patients had their own mobile phones. There was a telephone on each ward and patients could make phone calls in private. There was a separate telephone room, in the reception area at Stewart House where patients could make calls in private.

The service had an outside space that patients could access easily. Patients could make their own hot drinks at the drinks station and access a range of snacks and were not dependent on staff.

The food was not always of good quality. We received most feedback from patients and families and carers around meals. Many people commented the meals were boring, the menu repeated monthly and did not offer a variety of good quality food. Cultural food was provided to meet the needs of individual patients but also lacked variety. This was an issue identified at our previous inspection in 2018.

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, and supported patients. Most staff helped patients to stay in contact with families and carers.

Long stay or rehabilitation mental health wards for working age adults

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Some patients attended a community gardening group at a local leisure centre. Patients had trips out or walked to local shops.

Meeting the needs of all people who use the service

The service did not meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

One patient at Stewart House told us other patients made comments around their protected characteristics and staff had not care planned the needs of the patient.

A family member told us they were happy that staff supported their relative with their haircare as part of their protected characteristics.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. However, we saw the service patient information pack did not include information on how the service supported diversity and inclusion matters. We saw health and general information was accessible in different formats and languages including easy read.

Patients had access to spiritual, religious and cultural support. Patients had access to the trust's chaplaincy service. One patient told us there was a room to pray in and staff had offered a prayer mat but preferred a towel that could be washed regularly. We saw a patient listening to the Koran in the communal area.

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 service clearly displayed information about how to raise a concern in patient areas.

Managers told us there had been no complaints received in the last 12 months. Staff understood the policy on complaints and knew how to handle them.

Staff at Stewart House told us they received lots of compliments from patients, families and carers. The service used compliments to learn, celebrate success and improve the quality of care. Patients placed inspirational comments and message about their stay on a wall mural.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Long stay or rehabilitation mental health wards for working age adults

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.

Managers had the right skills, knowledge and experience to perform their roles. Two leaders were new to the service and worked with experienced leaders. Managers had a good understanding of the services they managed.

Staff told us that senior managers and service managers were visible and they knew who they were. Staff were complimentary about the trust senior leadership team including the chief executive officer.

Managers and staff confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

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

Staff were able to articulate the vision and philosophy of the wards.

Those staff we asked knew the organisation's vision and values 'Step Up to Great' and saw the values displayed throughout the wards. We heard about ongoing training for 'Step up to Great'. We saw evidence of the provider vision in team meeting minutes. Most staff were able to articulate the philosophy of the wards.

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.

Staff told us they felt happy and enjoyed their work. There was good staff morale. Staff felt respected, supported and valued. Staff felt able to raise their concerns without fear of retribution.

There appeared to be a good culture developed on the wards and staff had a good understanding of the service they provided. At the Willows some staff told us they had been concerned about the closure of two wards in 2020 with staff redeployed and impact on their jobs. Managers said there were ongoing consultation with staff before during and after changes were made.

Staff told us they promoted equality and diversity in their day to day work. However, diversity and inclusion were not included in the service patient information pack and within elements of care planning.

Governance

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

We saw some improvements in the service since our previous inspection in 2018. Areas included patient risk assessments and care planning, medicine management, ligature risk assessment, patient physical health care, patient involvement in care planning; but were not fully embedded across the service.

However, the trust did not ensure adequate governance to address all actions from the previous inspection were completed. Following our inspection in 2018, the trust planned to put in place, locked doors between male and female areas on wards at Stewart House. At this inspection, we found the doors had not been ordered.

The trust told us staff at the Willows had been working to improve risk assessment documentation with regular checks, but improvements were not evident. Some care plans were not personalised holistic and reviewed regularly. At Stewart House one patient's protected characteristics were not identified, care planned and actioned.

The trust did not use patient feedback to make improvements of the quality of food and review the repetition of meals and lack of variety. The trust had not ensured patient's privacy and dignity were protected.

The trust did not ensure staff consistently apply and record appropriate records for seclusion; or ensure staff are up to date with mandatory training including Mental Health Act.

The governance processes to monitor the service were not effective. This was an issue highlighted at our previous inspection in 2018.

Management of risk, issues and performance

Teams did not have access to all the information they needed to provide safe and effective care.

Managers had not carried out environmental checks of the garden at Stewart House. These issues relate to keeping patients and staff safe.

Effective multidisciplinary meetings across the service helped to reduce patient risks and keep patients and staff safe. Staff notified and shared information with external organisations. Staff were open and transparent and explained to patients when something went wrong. We saw staff had good rapport with patients.

Staff were offered the opportunity to give feedback and input into service development. Staff did this through regular team meetings.

Staff said the trust provided information governance systems to measure key performance indicators and to gauge the performance of teams. Managers had information that supported them.

Managers told us they had access to the risk register at ward level.

Information management

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

The trust had recently changed its electronic patient record system. Not all teams had timely access to the information they needed to provide safe and effective care. Staff at the Willows said they had difficulty navigating the main electronic patient record keeping systems; and uploading patient observations checks from the digital device due to the patient record keeping systems. The CQC inspection team found patients record systems were slow to access at the Willows.

Information governance systems included policy on confidentiality of patient records.

Long stay or rehabilitation mental health wards for working age adults

Managers had access to dashboards with information that supported them. All information was usually accurate and identified areas for improvement.

We saw the service patient information pack did not include information on how the service supported diversity and inclusion matters.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Engagement

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

Staff engaged in local and national improvements activities. The community rehabilitation team were created within 12 months as a response to the COVID-19 pandemic following faster discharges from wards. Two wards closed at the Willows, some of the staff transferred to the new community team.

Learning, continuous improvement and innovation

The multidisciplinary team developed an enhanced rehabilitation and recovery training programme for staff. This includes the recovery star meeting patients' goals. The psychology team have changed how talking therapy is offered and now provide outdoor therapy sessions. Patients reported benefits and felt more relaxed outside.

Managers supported development of new student nurses through a number of different routes including university students and those studying through Open University. We spoke with three students they said they felt welcomed and quickly made to feel part of the team.