

Requires improvement



Birmingham and Solihull Mental Health NHS
Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXT54	Northcroft site	Eden PICU Eden Acute George Ward Reservoir Court	B23 6AL
RXT47	Mary Seacole House	Meadowcroft PICU Ward 1 Ward 2	B18 5SD
RXTD3	The Barberry	Caffra PICU Melissa Suite Japonica Suite Magnolia Suite	B15 2SY

Summary of findings

		Tazetta Suite	
RXT37	Little Bromwich Centre	Newbridge House	B10 9JH
RXTD2	The Zinnia Centre	Saffron Ward Lavender Ward	B11 4HL

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- We found that the trust had not met all the requirement notices from our inspection in 2014. Ligatures were still an issue and fridge temperatures not being recorded consistently which meant that patient safety could be put at risk. At Newbridge House, Eden PICU, Eden Acute ward and George ward; we saw blind spots on ward areas that were not mitigated by staff observation or blind spot mirrors.
- Documentation was poor in some areas. We found some issues with Mental Health Act documentation and recording such as Section 17 paperwork not always showing detail of the conditions of leave or the number of escorts' required and capacity to consent to treatment forms in 43% of the patient records we looked at were not decision specific and did not show how decisions about a patients capacity had been made.
- The trust had a blanket search policy for patients returning from section 17 leave. This was not risk assessed or care planned to meet the needs of individual patients. Wards did not always apply this consistently and in line with the trust policy.

- Healthcare assistants did not have access to training in the Mental Health Act and Mental Capacity Act. This training would help them to support patients in understanding the restrictions placed on them.

However:

- Staff training levels were high and we found a well-motivated and engaged staff group. Consideration had been given to staff development and we found that a high number of staff had received specific training to give them the skills to take on extra responsibilities within their role.
- We observed staff to be caring and patient focussed. Care plans were complete and contained all the information that staff required to deliver care. We also saw that the trust is committed to patient involvement in service development. The trust had introduced peer support workers who were individuals that had accessed services in the past.
- Staff reported that they felt supported by their local managers. They stated that they felt that their managers went over and above to ensure that staff felt valued. We also found that teams supported each other and worked well together.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Ward areas had blind spots that had not been mitigated with equipment such as convex mirrors. Staff addressed this through observation but due to staffing levels and the needs of patients, this could not be done consistently.
- Recording of fridge temperatures across the service was inconsistent. Some wards had not recorded temperatures. This meant that staff could not be sure that medication had been stored at the correct temperature and was safe to use.
- There was high use of bank and agency qualified staff across the service and staff vacancies on some wards was high.
- We found evidence of blanket restrictions for searching patients returning from section 17 leave. Although the restrictions were clear in trust policy, application of these restrictions was not consistent across all wards we visited and were not individually risk assessed.
- We found that in 11% of the medication charts reviewed, staff had not monitored physical health signs after use of rapid tranquilisation.

However:

- All wards had risk assessments in place to mitigate the risks presented by the environment. For example, all wards had up to date and complete ligature risk assessments.
- Mandatory staff training levels were above 90% for all wards we inspected. This was above trust set targets of 85%.
- The service was using electronic recording systems well and this had led to improvements in care delivery. They were also using formats that were easy for patients to engage with to get information.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- Staff did not follow the latest guidance from the National Institute for Health and Care Excellence when prescribing medication. This was because the trust policy used guidance from 2005 rather than the latest guidance NG10 dated 2015 violence and aggression: short-term management in mental health and community.
- Access to psychological therapies was limited across all wards with the exception of Reservoir Court.

Requires improvement



Summary of findings

- Section 17 paperwork did not always give detail of the condition of the leave or the number of escorts needed. Evidence of nurses risk assessments relating to this were not always recorded. Section 17 leave was recorded in progress notes rather than the Section 17 leave file on the electronic recording system and it did not show who had copies of the forms.
- Recording around the Mental Health Act and the Mental Capacity act was poor across all of the wards that we inspected. We found areas where information was not completed and where the process around the Mental Health Act paperwork had not been implemented correctly.
- We found that not all care plans were holistic and recovery focussed and took into account the likes, dislikes, history and culture of the patient.

However:

- Staff supported patients with physical healthcare. We found good examples of when staff had arranged for patient to see specialists relating to physical health issues. Staff also used falls screening and the Waterlow tool for assessing the risk of pressure sores for patients where a risk was identified.
- Staff had the experience and qualifications for their roles. The trust trained healthcare assistants to take bloods and use the electro cardio grams machines. This helped to ensure these physical health checks were completed in a timely manner.

Are services caring?

We rated caring as good because:

- We observed high levels of staff and patient interaction during our inspection. Staff appeared to have developed effective relationships with the patient group and were able to tailor their interactions to individuals. Patients reported that staff were supportive and caring.
- There was evidence of patients and carer involvement in the care planning process. Both patients and carers attended multi-disciplinary meetings and had input into planning.
- The trust demonstrated a commitment to service user involvement in service development. We were told about the use of people who had used the service in the past to act as peer support workers.

However

- We found that not all care plans were personalised and written from the patient's point of view.

Good



Summary of findings

- Not all patients had received copies of their care plans and it was not always recorded that they had refused to take these.

Are services responsive to people's needs?

We rated responsive as good because:

- All wards we visited were well equipped. Though some were small, they were all well laid out and consideration had been given to patient engagement. Rooms had been set aside for patients to have quiet space, private visits and make private telephone calls. There were activities available across the service and rooms had been set aside and equipped to facilitate this.
- Patients received a welcome pack on arrival at the wards and although these varied in quality, they contained relevant information about patients' rights, support for carers and expectations of the ward. Staff informed us that there was easy access to interpreters including signers. Patients had good access to spiritual support across all the wards
- The 'See Me' team and the peer support workers were ex patients employed by the trust both had a regular presence on the wards so patients could raise concerns at a very early point. The 'See Me' team facilitated community meetings on wards and could feed concerns back to the trust through governance meetings. The wards received very few complaints but staff stated they received feedback after a complaint through supervision, handover or team meetings.

However:

- The average bed occupancy was high across the acute wards. Due to a shortage of beds, patients were allocated a bed that was not always on the ward nearest to their home.
- Patients did not always have a bed on the same ward or hospital site following a period of leave.
- All information leaflets on the wards were in English. Staff said leaflets in other languages were available on request although we did not see signs in other languages making this clear to patients.
- The entrance doors to the ward at Newbridge House had windows, which were opposite the outpatients waiting area. This could affect the dignity and confidentiality of patients on the ward.

Good



Are services well-led?

We rated well led as Good because:

Good



Summary of findings

- Staff knew the trusts values and could talk about them. The values formed part of supervision and appraisals and were an integral part of the Safewards work that wards were engaging in.
- Some of the ward managers were fairly new in post but all were motivated to affect change in their wards and improve the care and support of patients.
- Staff knew who senior managers were and stated that local managers regularly visited the wards.
- Staff received mandatory training and had a compliance rate over 90%. Most staff received regular management supervision.
- Staff morale on most wards was good despite the fact they felt under pressure due to staffing levels and the acuity of patients. Healthcare assistants had the opportunity to train to be band 4 associates and staff felt opportunities were available if they wanted to progress in their careers.

However

- We identified a number of lapses in governance at ward level including care plans that were not always holistic, lack of audits on some wards and monitoring of physical health after the use of rapid tranquilisation.
- Wards had enough staff to cover shifts based on establishment figures but the acuity of the wards, the high use of bank and agency staff and the blanket search policy relating to patients returning from section 17 leave meant qualified staff in particular stated they did not always have the time needed to focus on patient care.

Summary of findings

Information about the service

The acute wards and psychiatric intensive care units for adults of working age provided by Birmingham and Solihull Mental Health NHS Foundation Trust are based over six sites in Birmingham. The trust has a total of 12 acute wards and three PICUs. We inspected all wards.

There are five wards based at the Oleaster. Two of these are acute admissions wards, two are assertive outreach wards and one is a PICU.

- Caffra suite -10 bedded male PICU
- Tazetta suite- 16 bedded male acute ward
- Melissa suite – 16 bedded female acute ward
- Japonica ward – 16 bedded female assertive outreach ward. At the time of the inspection, the ward had 4 assertive outreach patients and 10 acute patients.
- Magnolia ward – 16 bedded male assertive outreach ward. This ward had 12 assertive outreach patients and 4 acute patients when we inspected.

Mary Seacole House had three wards two acute wards and one PICU.

- Meadowcroft – 10 bedded male PICU

- Ward 1 – 16 bedded male acute ward
- Ward 2 – 14 bedded female acute ward

The Zinnia centre has two acute wards.

- Saffron ward – 16 bedded male acute ward
- Lavender – 16 bedded female acute ward

There are three wards at the Northcroft site. Two of these are acute wards and one PICU.

- Eden PICU – 8 bedded female PICU
- Eden Acute – 16 bedded male acute ward
- George ward – 16 bedded male acute ward.

Newbridge House is a standalone unit with one ward, which we inspected. It is a 16-bedded ward for females. This ward has strict eligibility criteria and takes patients who are lower risk due to the fact it is on its own and only has outpatient facilities in the rest of the building.

Reservoir Court is a 24 bedded mixed gender all age ward catering for people with mental ill health and physical health issues. The ward is managed as part of the adults of a working age team although most of its patients are over the age of 65.

Our inspection team

The team that inspected Birmingham and Solihull Mental Health NHS Foundation Trust was led by

Chair: Mick Tutt, Non-executive director, Solent NHS Trust

Head of Inspection: James Mullins, Care Quality Commission (CQC)

The team that inspected this core service comprised of four CQC inspectors, two Mental Health Act reviewers, 13 specialist advisors including doctors, nurses and occupational therapists and an Expert by Experience.

Why we carried out this inspection

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

Birmingham and Solihull Mental Health NHS Foundation Trust was last inspected in May 2014. At that time, psychiatric intensive care units had an overall rating of good. Acute wards received a rating of requires improvement with the following requirement notices

Summary of findings

- The trust must ensure that all people who use the service are protected against the risks associated with the unsafe use and management of medicines.
- The trust must ensure that all records for people who use the service are accurate and fit for purpose. The trust must ensure that all ligature risks are assessed and action taken to reduce these.
- The trust must ensure that the people who used the service at Mary Seacole House and Newbridge House have access to physical health care medical staff when needed.

Reservoir Court was inspected in November 2016 but not rated and was found to have the following breaches

- The trust must ensure that all patients have an up to date risk assessment and risk management plan and that these are reviewed and reflect changes in risks.
- The trust must take action to ensure ligature risk points are reduced and the ward environment is reassessed promptly following any ligature incidents.
- The trust must ensure staff carry out and record patient observations in line with trust policy.

- The trust must make sure all bank and agency staff aware of where lifesaving equipment is kept.
- The trust must ensure care plans meet the need of patients and that staff complete these in a timely manner.
- The trust must undertake audits of care records to ensure that any deficits in patients' care records are identified and amended.
- The trust need to ensure that all equipment is fit for purpose and that staff record logs of maintenance and calibration of equipment accurately.
- The trust must ensure that staff receive regular managerial and clinical supervision, as well as yearly appraisal.
- The trust must ensure that staffing levels and grade on shift meet the agreed standard.
- The trust must ensure that medical leave is consistently covered.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited all fifteen of the wards at the six hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 40 patients who were using the service and four carers
- spoke with the managers or acting managers for each of the 15 wards
- spoke with 89 other staff members; including doctors, matron, nurses, healthcare assistants, clinical psychologists, occupational therapists, peer support worker, "See Me" workers, support time and recovery worker, administrators and domestic staff.
- spoke to the independent mental health advocacy service
- attended and observed three hand-over meetings, four multi-disciplinary meetings and a ward community meeting.
- collected feedback from 59 patients using comment cards.

Summary of findings

- looked at 108 medication charts of patients and 67 patient records
- reviewed Mental Health Act records of 39 patients
- carried out a specific check of the medication management on one ward
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We received 59 comments cards and spoke to 40 patients and four carers. Thirty of the comments cards had positive comments about the quality of patient care, the food and the clean environments. Negative comments included those about the smoking ban, communication

and staffing levels. Twenty-six of the patients we spoke to said they felt safe on the wards and that staff treated patients in a caring and respectful manner. Two of the carers stated that they did not feel listened to when they raised concerns.

Areas for improvement

Action the provider **MUST** take to improve

Action the provider **MUST** take to improve

- The trust must consider using mirrors on wards with multiple blind spots to mitigate against ligature risks to patients.
- The trust must ensure fridge temperatures are monitored and recorded routinely and that staff know the procedure for reporting issues when they arise.
- The trust must ensure healthcare assistants receive training in the Mental Health Act and Mental Capacity Act.
- The trust must ensure section 17 leave paperwork is completed fully, recorded properly and accessible to patients.
- The trust must ensure that capacity to consent to treatment forms are completed and decision specific.
- The trust must ensure section 62 paperwork is reviewed and that referrals are made to SOAD in a timely manner.
- **The trust must ensure that it undertakes active and individual assessment of risks posed to patients who return from leave and use this in order to base decision on searches**

Action the provider **SHOULD** take to improve

Action the provider **SHOULD** take to improve

- The trust should improve access to psychological therapies for patients on acute/PICU wards.
- The trust should ensure all wards are completing regular audits.
- The trust should review the windows in the entrance doors to the ward at Newbridge House as this could compromise patient's privacy and dignity.
- The trust should display notices in other languages explaining that leaflets in those languages are available on request.
- Trust should ensure that the prescribing, administration, and monitoring of physical health of patients are completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.
- The trust should address the issue of beds and the fact patients on overnight leave sometimes have to return to another ward effecting continuity of care.
- **The trust should review the actions it takes when an informal patient refuses to be searched on admission**

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Eden PICU Eden Acute George Ward Reservoir Court	Northcroft Site
Meadowcroft PICU Ward 1 Ward 2	Mary Seacole House
Caffra PICU Melissa Suite Japonica Suite Magnolia Suite Tazetta Suite	The Barberry
Newbridge House	Little Bromwich Centre
Saffron Ward Lavender Ward	The Zinnia Centre

Detailed findings

Mental Health Act responsibilities

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

The wards had not been subject to any independent Mental Health Act visits from April 2016 – March 2017.

Ninety five percent of qualified staff had received training in the Mental Health Act however training was not mandatory for healthcare assistants who relied on asking qualified staff for guidance.

Section 17 paperwork did not always detail the conditions of leave or the number of escorts required. Staff recorded information incorrectly in the progress notes rather than the section 17-leave file in patient records. We could not see who received copies of this paperwork.

Completed capacity to consent to treatment forms were not decision specific and it was not clear how decisions around capacity had been made.

Staff used section 62 paperwork on a regular basis because referrals to the second opinion appointed doctor had not been made in a timely manner.

Patients had regular access to the independent mental health advocacy service who attended ward reviews on a regular basis.

Mental Capacity Act and Deprivation of Liberty Safeguards

Eighty two percent of qualified staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was not mandatory training for healthcare assistants. The policy was accessible to all staff on the trusts intranet.

Qualified staff demonstrated a good understanding of the MCA and its five guiding principles however capacity

assessments were not decision specific and records did not show how decisions about capacity had been decided in all cases. They did not show if decisions had been made in the best interests of the patient.

Staff knew how to make DoLS applications and the purpose for making these. The wards reported low use of this legislation.

Are services safe?

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

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

Our findings

Safe and clean environment

- The wards at Oleaster and the Zinnia centre had no blind spots and staff could observe all areas. Newbridge House, Eden PICU, Eden acute, George ward, Reservoir Court and the wards at Mary Seacole House all had blind spots and areas that staff had to check on a regular basis. Staff showed awareness of these areas but they could not observe these areas constantly due to staffing levels and the needs of the patients. Wards did not have mirrors in place, which would have helped to reduce the potential risks for patients. The trust reported no incidents had occurred, that when investigated, had identified blind spots as a factor
- All wards had ligature points and staff assessed these as part of the environmental risk assessment and the ward specific ligature risk assessments all were adequate and up to date. There was evidence that audits had been updated following recent incidents on Eden PICU and Japonica Ward.
- All wards complied with guidance on same sex accommodation. Reservoir Court was a mixed gender ward with clearly defined areas for both genders.
- Staff ensured the wards had well maintained clinic rooms and had a full range of equipment that was up to date. Although these areas were small in Mary Seacole House, they were adequate. The clinic room at Newbridge House was cluttered which made the space difficult to use.
- We found issues with fridge temperatures on some wards. On Ward 2 at Mary Seacole House the fridge was not working and they had to use a fridge on another ward. On George Ward, the temperature had not been recorded for a total of eight days across January and February. At Newbridge House, the fridge was unlocked and the temperature had not been recorded six times in a three-month period and had been above the maximum on two occasions but this had not been reported. On Eden, acute staff had not recorded the fridge temperature on 27 occasions over a three months period. There had been another six occasions where the fridge had been broken. Staff had reported this and disposed of medication. On Eden PICU, the fridge was unlocked and the fridge temperature had been out of range 28 times over a period of 36 days. This included six occasions when staff had not recorded the fridge temperature.
- All wards had emergency life support bags and some wards had immediate life support bags for use across the hospital site. Staff checked these on a daily basis.
- Eden, Meadowcroft and Caffra PICUs had seclusion rooms that allowed for clear observation, two-way communication and had a toilet and a clock.
- All wards had a regular housekeeper and two domestic staff. Wards were clean with good furnishings and cleaning records had been completed. All wards scored above the England national average of 97.8% for cleanliness in the patient-led assessments of the care environment except those at Oleaster who scored 97.5%. All wards were above the national average of 94.5% for condition, appearance and maintenance of wards.
- Staff adhered to infection control principles and carried handwashing gel and this was available on all wards along with handwashing posters.
- Equipment was clean and well maintained and had up to date electrical safety stickers attached.
- Environmental risk assessments were undertaken and updated regularly. These were comprehensive and covered areas such as manual handling, legionella, lone working, first aid and biological hazards.
- Staff carried alarms on all wards; the alarms could be activated to sound locally on the ward or across the hospital site. Managers stated that daily checks of alarms took place and staff signed them in and out when they came on duty. Tazetta ward did not have enough alarms for all staff but had more on order. We saw on the Oleaster site that when a member of staff pulled her alarm it did not work. Fortunately, staff on reception acted promptly to activate the alarm and we saw that staff responded quickly to this.

Safe staffing

Are services safe?

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

- Establishment figures in November 2016 for PICUs was 17 whole time equivalent (WTE) qualified staff and 13.5 WTE health care assistants (HCAs). Each acute ward had 14 WTE qualified staff and nine HCAs except Reservoir Court which had 14.5 WTE qualified and 12 WTE HCAs. Establishment figures were decided based on the trusts policy for this.
- Managers ensured that there was two qualified staff on shift at all times and where possible one of the qualified staff was a deputy ward manager. The trust had recently decided to incorporate occupational therapists into the establishment figures. As well as their normal role, they were supporting the wards with key tasks such as attending ward rounds and helping with observations. This had been a recent change and it was too early during the inspection to comment on how it was working. Managers completed two shifts a week as part of the establishment figures.
- The wards had 27 vacancies for qualified staff across the 15 locations at the end of March 2017. Newbridge House had the highest number of vacancies at five. Caffra PICU, Melissa Ward and Reservoir Court had no vacancies. Wards reported seven HCA vacancies across all sites. Reservoir Court had the highest number with three vacancies. Managers reported that recruitment for qualified staff often took several months and these delays added to the pressure on permanent staff.
- From 1st December 2015 – 20th December 2016, bank staff had covered 40% of vacant shifts for qualified staff and 37% by agency. Bank nursing assistant covered 44% of vacant shifts. The wards with the highest number of shifts covered were Newbridge House with 403 shifts and Japonica ward with 324 shifts. The total number of shifts not filled was 358, with Japonica ward having the highest number at 58. Japonica was a new ward, which opened in September 2015. Initially the trust staffed this ward with a combination of experienced staff from another ward and bank and agency until recruitment was completed. All managers reported that where possible they preferred to use bank staff who knew the wards but that sometimes at short notice this was not possible and they had to use agency staff. Staff sickness for 1st December 2015 – 20th December 2016 was at its highest for Newbridge House at 21% and the lowest for Eden PICU at 2%. Managers said they were addressing sickness through management supervision and by using the trust's policy although where the figures were high. This was due to long-term sickness and maternity leave.
- Managers could alter the staffing levels to meet the needs of patients. The first set of observations was absorbed into the establishment staffing numbers but after that, they could request additional staff to support the observations of patients. The first set of observations did affect staffing levels as some wards had patients who had been on 1:1 or 2:1 observations for several weeks.
- Staff stated that patient's 1:1 time with their named nurse, escorted leave and activities were cancelled on occasions due to staffing levels and meeting the wide range of needs on the wards although they tried to avoid this where possible or put in replacement times so that patients still had access to these.
- A qualified member of staff was present in communal areas at all times.
- Wards had enough staff to carry out physical interventions when required although this took them away from other areas of the ward and affected the time spent with other patients.
- There was adequate medical cover and a rota covered this out of hours. Managers reported that there had been an issue with access to junior doctors in an emergency during the hours of 9am – 5pm with patients having to wait for a consultation. This had recently been resolved with a rota put in place during the day where junior doctors could be paged if needed. Most wards had one consultant psychiatrist however on the assertive outreach wards Magnolia and Japonica patients had their own assertive outreach consultants. There was also a general ward consultant to cover non-assertive outreach patients on those wards. This meant these wards could be dealing with up to seven consultants and multiple ward reviews each week. This affected the amount of time staff could spend on patient care.
- Staff had received mandatory training, which included safeguarding adults' level 2, Infection control and equality and diversity. All wards had a compliance rate of over 90%. Managers used a traffic light dashboard system for monitoring staff compliance with training.

Are services safe?

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

Assessing and managing risk to patients and staff

- From 1st March 2016 – 28th February 2017, there had been 129 episodes of seclusion. Eden PICU had the highest number at 49 and Magnolia, Tazetta, and Ward 1 reported no episodes of seclusion for this period.
- Reservoir Court reported one incident of long-term segregation in the same period. There were none recorded for the other wards.
- There were 1405 episodes of restraint across the 15 wards from 1 March 2016 – 28 February 2017. Eden PICU had the highest number at 282 on 47 patients, Meadowcroft PICU had 106 restraints on 54 patients, and Caffra PICU had 193 restraints on 51 patients. Of the acute wards, Lavender Ward had the highest number with 134 restraints on 48 patients while Ward 1 had the lowest number with 32 restraints on 25 patients. There were 835 episodes of prone restraint across all wards with Eden PICU having the highest number of 201. Staff recorded restraint as prone in line with the trusts policy even if a patient was only in that position for a very short period. All ward recorded incidents of restraint. Staff had received Approaches to Violence through Effective Recognition and Training for Staff (AVERTS), which a dedicated team at the trust provided. Wards had implemented the use of the Safe wards model to explore how staff communicated with patients and how this could reduce the need for restraint by using clear open communication and positive language. The AVERTS team monitored the use of restraint on wards and supported staff to manage this where individual patients had been identified as having high levels of restraint. We observed staff using de-escalation techniques where possible and staff discussed details of possible high-risk situations in hand over to try to avoid the need to use restraint. Managers on the PICUs reported that while sometimes using restraint was unavoidable, they used de-escalation techniques and seclusion as a least restrictive option where possible.
- We reviewed 67 patients' records. All risk assessments were comprehensive and on Eden PICU we saw that these had been updated to reflect incidents as they happened. Staff had not updated risk assessments in three records that we looked at across all wards. All wards used the risk assessment checklist available of the electronic recording system, which came in two parts. The first part is for screening and the second is the detailed risk assessment. They also used HCR-20 a tool for violence risk assessment and management
- The trust operated a no smoking policy, which included patients not being allowed to smoke on escorted leave. Cigarettes were on the contraband list so staff took these from informal patients on return to the ward. Staff implemented the policies for smoking and searching but this was not consistent in the way it was applied across all the wards. Staff reported that the smoking ban and the fact that from February detained patients could no longer smoke, when on escorted leave with staff, had increased incidents on the ward and aggression towards staff. Staff explained the ban to patients on admission to the ward and encouraged patients to use e-cigarettes and access the smoking cessation programmes available.
- The search policy was gender specific and male staff on male wards felt this affected the amount of time spent on patient care, as they regularly had to complete searches on both detained and informal patients. One staff member stated that he had completed 13 searches in a seven-hour shift and this impacted on patient care, 1:1 time, escorted leave and activities. In the records we reviewed, we saw the searches had not been care planned for most patients and capacity to consent to searching had not been recorded. The trust had audited the quality and consistency of searches in January 2017 but this did not include action points. Staff on the PICUs searched patients on admission and then on an individual basis, when required as patients had escorted leave. Staff did not apply the policy consistently across the acute wards with some searching based on individual risk and others applying the policy to all patients. The trust had not looked at the impact of searches on staffing levels and patient care.
- Informal patients could leave the wards when they wanted to although staff spent time exploring potential risks with patients before they left the ward.
- Staff used trust policies for observations and recorded these appropriately.
- Wards used rapid tranquilisation as set out in the trust policy. However, the trust policy, dated March 2015 and ratified in November 2016, referenced National Institute

Are services safe?

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

for Clinical Excellence 2005: Violence- the short term management of disturbed or violent behaviour in psychiatric inpatient settings and emergency department. It does not refer to the latest 2015 NG10 guidelines for managing violence and aggression, where lorazepam and anti-psychotics were prescribed and administered together. Acute wards recorded 753 uses of rapid tranquilisation on 297 patients from 1st March 2016 – 28th February 2017 with Lavender ward having the highest figure of 129 incidents of use on 48 patients. PICUs recorded 517 uses of rapid tranquilisation on 152 patients. Eden PICU had the highest number with 246 incidents on 47 patients. Staff stated that the use of Safewards and the support of the AVERTS team were supporting them to look at ways of reducing the use of rapid tranquilisation. Of the 108 medication charts we looked at, 11% did not show that staff had monitored physical health signs after use of rapid tranquilisation. This was not in line with National Institute for Health and Care Excellence guidance [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.

- Wards used seclusion in line with the trust's policy. Where they did not have a seclusion room, they used a bedroom until a suitable alternative was available. We found in two cases staff had not fully completed the seclusion records. For example, we found that an independent MDT review had not been completed on one record and where a patient had been secluded in their bedroom the seclusion had not been ended formally. A doctor had not attended within one hour at the start of the seclusion and no MDT reviews had taken place. This did not comply with the Mental Health Act code of practice.
- Staff received training in safeguarding adult's level two and each ward had a safeguarding lead. Wards reported 100% compliance in this area. Staff understood how to report concerns and spoke highly of the support received from the trusts safeguarding team.
- Medicines were stored securely and the wards received visits from the pharmacist and a pharmacy technician who carried out regular audits. The electronic medicines administration record was linked to the British National Formulary, which alerted staff to issues with prescribing. Reservoir Court still used paper medication charts with a view to moving to the electronic system in May 2017.

- Staff showed an awareness of addressing issues such as falls and pressure ulcers, especially at Reservoir Court where patients were physically frail. On other wards, staff demonstrated a good understanding of issues such as blood borne viruses and had good contact with physical health nurses to manage this.
- All wards had areas for children to visit. These were situated off the wards or at the entrance so that children did not come into the main ward areas. On PICUs, staff risk assessed patients before children could visit.

Track record on safety

- The trust reported there had been eight serious incidents relating to these wards from 1 November 2015 – 31 October 2016. The highest number of four was for apparent/actual/suspected self-inflicted harm.
- Staff gave examples of recent adverse events and learning from these. Staff on Meadowcroft PICU described an incident with a patient breaking a window. The patient used stones gathered from the outside space to damage the window. The trust replaced the grass with astroturf so this was no longer possible and to help prevent future incidents.
- Following an incident where a patient's increased risk was not recorded at handover, the patient was allowed to go on leave during the next shift, and an incident occurred. The trust introduced the 'WHAT' tool an interactive and comprehensive electronic handover form, which looked at what happened, history, action and task. All staff had access to this as they needed it.

Reporting incidents and learning from when things go wrong

- Wards used an electronic system for recording incidents. All staff reported that this was easy to use and they understood what to report.
- The 15 wards recorded 1524 incidents from 1 December 2016 – 28 February 2017. These included assaults (physical), aggressive behaviour, medication, staffing issues, and threats to harm others.
- Staff gave examples of speaking to patients and carers when things went wrong and consideration of duty of candour was on the incident recording form.
- Staff received feedback from incidents via email, in management supervision, team meetings and at

Are services safe?

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

handovers. There was the opportunity to debrief in the reflective practice meetings facilitated by psychotherapists on the wards and in sessions with ward managers.

- Staff said that they received lessons learnt and action points from incidents. They gave examples such as making changes to how staff approached patients when giving medication and which staff might be most

appropriate to carry out searches, undertake escorted leave etc. so that patients felt more comfortable. Melissa Ward had put up a whiteboard so that patients could see who is available to them for 1:1 time if their named nurse was off duty. This had a positive impact for patients who no longer felt that they had to wait for someone to be free of other duties.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- We examined 67 patient records. Staff completed 72-hour assessments in a timely manner following admission and undertook a more detailed assessment once the patient had settled on to the ward.
- Staff completed physical health examinations on admission and documented if a patients refused this. Following the initial assessment, they completed the Rethink physical health check tool, which looked at a range of issues including lifestyle, family history, medication and diet. These assessments were comprehensive and detailed.
- We looked at 67 care records and found that in 39% of cases, care plans did not contain information that was holistic, personalised and recovery focussed. We found that the standard of care plans on some wards such as Eden PICU, Meadowcroft PICU, Caffra PICU, Melissa and Magnolia wards were of a better standard than those on Wards 1 and 2, Lavender Ward, Saffron Ward, Newbridge House, Eden acute, George Ward, Japonica Ward, Tazetta Ward and Reservoir Court.
- Staff used an electronic recording system for patient's records and administering medication so staff could access information if a patient moved ward. Agency staff did not have access to the electronic records system, which permanent staff stated added to their workload and administration tasks.

Best practice in treatment and care

- Staff did not follow the latest guidance from the National Institute for Health and Care Excellence when prescribing medication. This was because the trust policy used guidance from 2005 rather than the latest guidance NG10 dated 2015 Violence and aggression: short term management in mental health, health and community settings.
- Access to psychological therapies was limited across all wards except Reservoir Court who had twice-weekly visits from a psychologist. Psychologists screened patients to make sure those most in need could receive an individual therapy programme. Ward staff could make individual referrals to psychology if needed.

- Staff supported patients with physical healthcare. We observed staff referring one patient to the doctor, as they felt concerned about his physical health. Staff could make referrals to specialist services such as speech and language therapy, the diabetes nurse and the tissue viability nurse.
- Wards used the health of the nation outcome scales to record outcomes for patients. Occupational therapists used the model of human occupation screening tool as part of their assessments.
- Wards contributed to trust wide audits such as care planning, risk, and a section 17 leave audit but these were not specific to wards at a local level. Japonica, Tazetta, Lavender, Melissa, Magnolia and Ward 1 carried out ward based audits including infection control, supervision and physical health. Managers of the other wards said they had been working towards starting audits. The trust had audited the quality and consistency of searches in January 2017 but this did not include action points.

Skilled staff to deliver care

- Wards had mixed teams made up of health care assistants, nurses and occupational therapists (OT's). The OTs had recently been allocated to wards as part of the establishment figures and had taken on tasks normally fulfilled by nursing staff. They reported that they had received training to do this and felt supported by ward managers however; they felt concerned about losing their professional identity. OT's had one day a week where they were outside of the establishment figures so they could complete their assessments but felt this was not long enough to complete these and write reports. Ward staff reported that access to psychology was limited. Some wards did not have OT's as they were waiting for them to be recruited.
- Staff had the experience and qualifications for their roles. The trust trained healthcare assistants to take bloods and use the electro cardio gram machines, which measured the electrical activity in a patient's heart. This helped to ensure these physical health checks were completed in a timely manner and reduced the workload of qualified staff and junior doctors.
- The trust trained healthcare assistants to NVQ level 3 and they had the opportunity to apply to take part in a programme to become a band 4 associate. Staff

Are services effective?

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received an induction before starting work on the wards however; we did not see any evidence of inductions for bank and agency staff except at Reservoir Court who had implemented this.

- Staff received management supervision every 6 – 8 weeks and could choose to access clinical supervision with a supervisor of their choice. Managers reported that on occasion, supervision was missed due to staffing issues. Wards provided reflective practice groups for staff every two weeks. Staff had appraisals and attended ward handovers and team meetings.
- The overall compliance rate for non-medical staff appraisals was 84% when taken over 12 months from 1st October 2015 to 31 October 2016. The lowest rate was for George Ward at 74%. Meadowcroft PICU had the highest rate at 95%.
- Managers reported that they addressed poor staff performance informally through management supervision initially where managers gave staff additional support through mentoring and close management of targets. Managers could involve HR if things could not be resolved at a local level or the issue was serious.

Multi-disciplinary and inter-agency team work

- Regular multi-disciplinary team meetings took place and involved a range of staff, patients and carers on all wards.
- Staff gave detailed handovers between shifts and the information from these was available to all staff on the ward.
- Staff reported that they had good working relationships across the wards and the PICUs offered support if acute wards had patients in seclusion. The assertive outreach wards stated that they worked well with the assertive outreach teams who referred patients to them. Wards worked with crisis and community mental health teams to ensure good handovers of patients care.
- Staff worked well with external teams such as speech and language therapists, physiotherapists, tissue viability nurse and the diabetes nurse. However, staff stated that there were delays in accessing social services for patients and ward staff often spent time

sorting out issues such as housing for patients so that they could be discharged from the wards. Reservoir Court had their own social worker to support patients with this type of issue.

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

- Qualified staff examined Mental Health Act (MHA) paperwork on a patient's admission. The wards had access to a MHA administrator to support them in making sure the paperwork was in order and up to date.
- Section 17 paperwork did not always give detail of the condition of the leave or the number of escorts needed. Evidence of nurses risk assessments relating to this were not always recorded. Section 17 leave was recorded in progress notes rather than the Section 17 leave file on the electronic recording system and it did not show who had copies of the forms.
- Ninety five percent of qualified staff had received training in the MHA and the Code of Practice. They demonstrated a good knowledge of how and when to use this. Healthcare assistants did not receive training and relied on knowledge they had picked up from nurses and through handovers.
- Consent to treatment forms were not detailed or decision specific. It was not clear how staff had made decisions around capacity, as this was not recorded. The electronic medication administration record did not allow for certificate of consent to treatment to be attached to records. These paper documents should be kept in the clinic room so that they could be checked when medication was administered so that nurses can see the legal authority under which medication is being administered. Eden PICU did not have this information available in their clinic room.
- We saw evidence that most patients had their rights explained to them on admission and at ward rounds on an ongoing basis.
- Wards received administrative support and legal advice through the Mental Health Act administrator and through the trusts central team.
- Detention paperwork was in good order, however, section 62 paperwork (certificate of emergency treatment) was being used on a regular basis for some patients because timely referrals to the second opinion

Are services effective?

Requires improvement 

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appointed doctor (SOAD) had not been made and in some cases there was no evidence they had been made at all. Section 62 paperwork did not appear to be monitored and the MHA administrator was not aware that this was the responsibility of the hospital managers. In one case where a patient had been administered electroconvulsive therapy under section 62, there was no evidence that a staff had made a prompt referral for SOAD. Another patient detained under the Mental Health Act (1983) had legal documentation for treatment for mental disorder, which was not completed accurately, (prescribed medicine at a dose higher than that stated on the section 62 forms).

- The MHA team provided regular audits of the MHA paperwork. Learning from audits was shared with wards to support continuing improvement.
- Patients had access to the independent mental health advocacy service. We saw evidence of staff making referrals and the advocate regularly attended ward reviews and visited patients on the wards.

Good practice in applying the Mental Capacity Act

- Eighty two percent of qualified staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was not mandatory training for healthcare assistants.

- The wards had made no DoLS application from January 2016 – January 2017.
- Qualified staff demonstrated a good understanding of the MCA and its five guiding principles. They showed good knowledge on how this applied to patients in their care. Healthcare assistants had limited knowledge but knew they could ask qualified staff for advice.
- The Mental Capacity Act policy was stored on the trusts intranet and available to all staff.
- Of the 67 care records we looked at capacity to consent was not decision specific in 43%. In these records, the capacity decisions were multipurpose covering both consent to treatment and consent to admission on to the ward. Records did not show how decisions about capacity had been made or whether these were in a patient's best interests.
- Qualified staff understood the MCA definition of restraint and how this applied to patients.
- Staff knew who to contact within the trust for advice and guidance.
- Staff knew how to make DoLS applications if required.
- The trust audited adherence to the MCA. Lessons learnt were passed to ward managers for action to be taken.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff treated patients with dignity and respect. We observed that staff spent time talking to patients and provided practical and emotional support. Staff supported patients who had been homeless at the time of admission by buying items such as slippers to make them feel more comfortable and providing a safe storage space for their belongings.
- We interviewed 40 patients; twenty-six patients who expressed a view reported that staff were kind and caring
- Staff understood the needs of individual patients. We saw staff had developed ways of communicating with patients who had additional needs such as a learning disability and autism by using picture cards.
- All wards scored 98.9% or above in the patient led assessments of care environment survey for privacy, dignity and respect.

The involvement of people in the care they receive

- Staff introduced and orientated patients to the ward on admission. Patients and carers received welcome packs, which gave information about the ward, how to complain and what the patient could expect from the ward. They also gave information about the smoking ban and search policy and the reasons for this.
- Seventeen patients out of the 40 we spoke to reported that they had access to a copy of their care plan if they wanted one. We found that not all care plans were personalised and written from the patient's point of view. Patients attended ward reviews and multidisciplinary meetings and we observed that most patients engaged well in the meetings and could contribute to the discussion.
- Patients had access to advocacy who visited the ward on a regular basis.
- Families and carers were invited to ward reviews and meeting with the permission of the patient. Wards had boards with information for carers. One carer stated that pre-booked visits had not always gone ahead as staff said they had no booking details.
- Patients had lots of opportunity to feedback on the service they received. They could do this by completing a form, in community meetings or by talking to the peer support worker or the 'See Me' worker.
- We did not see evidence on the wards of patients being involved in service development and recruitment although the trust showed a commitment to using former patients by employing them as peer support workers.
- Advanced decisions were incorporated into care plans including information on what support they needed when in a crisis and who they would want to be contacted.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- Referrals to the wards were received from crisis teams, rapid assessment interface and discharge teams, community mental health teams, assertive outreach teams, the psychiatric decisions unit and the police through the health-based place of safety. The key performance indicator (KPI) for length of stay on acute wards was 28 days. Reservoir Court had the highest average length of stay for 12 months from 31 March 2016 – 28 February 2017 with 85 days. Melissa ward had the lowest with 32 days. PICUs did not have a KPI for length of stay. Eden PICU had the highest average with 65 days and Meadowcroft the lowest with 36 days. Staff showed a commitment to working towards this and spoke of the need to keep patients for the shortest time possible where the needs of the patients allowed for this to happen.
- The average bed occupancy for acute wards was 108% for 12 months from 31 March 2016 – 28 February 2017. In the same period, the bed occupancy for the PICUs was 97%. The lowest bed occupancy rate was for Eden PICU at 90%. The highest was Saffron ward at 114%. Figures were high as a bed could be allocated to two patients at the same time if one patient was on leave when a new patient being admitted needed the bed.
- There were 164 out of area placements between 01 December 2015 and 30 November 2016. The longest placement lasted 372 days. Three of the placements were reported to have lasted longer than six months. Twenty one patients were transferred to another trust just six miles away during the 12 month period. Managers stated that the trust was talking to commissioners about the issue of bed availability to explore whether this could be increased.
- The trust had a bed management team who looked at the availability of beds on a daily basis. Due to a shortage of beds, patients were allocated a bed that was not always on the ward nearest to their home.
- Patients on overnight leave occasionally found that no bed was available upon their return and they would be allocated a bed in another ward, which might not be on the same hospital site. This could affect continuity of care for patients when this happened. This had happened 38 times across all the acute wards in a 12-month period from 1 April 2016 – 31 March 2017 with Ward 1 and Eden acute having the highest number of seven patients each.
- Staff discharged patients during daytime hours and at a time to suit them.
- Due to high bed occupancy patients, needing a bed on a PICU had to wait for a bed to become available. These patients would continue to be managed by the crisis teams or on the acute wards with support and advice from the PICU's. Staff worked with bed managers to ensure the wait for a bed was resolved as quickly as possible with most patients being transferred the next day or within two days.
- Patients who required a more intensive level of service were secluded in bedrooms until a bed became available on a PICU. This happened for the shortest time possible and staff worked with bed managers to ensure moves happened as soon as a bed was available. Staff followed the trusts policy on seclusion during these incidents.
- From 01 December 2015 to 30 November 2016, there were 58 delayed discharges for this core service, which equates to 3%.
- Care plans referred to section 117 aftercare services for eligible patients. Section 117 of the Mental Health Act states that patients detained under the Mental health Act are entitled to funding for aftercare services to meet the needs that arise from having a mental health problem or to help prevent readmission to hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- All wards at Oleaster, the Zinnia Centre, Reservoir Court, the Northcroft site and Newbridge House had a full range of rooms and equipment to support treatment and care. These included activity rooms, sensory areas and lounges. Mary Seacole House had less space and this limited the amount of quiet areas and meeting rooms available to patients and staff. Areas for staff on breaks at Mary Seacole were limited and they had no access for purchasing meals on site or in the local area. The trust had agreed that hot meals could be delivered from another site for staff to have on their breaks.
- The doors to the ward of Newbridge House had glass panels in them. The outpatient waiting area was placed

Are services responsive to people's needs?

Good 

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

opposite the doors and it was possible to see in to the corridor of the ward. Although it was not possible to identify patients, we could see them moving around the ward and this could affect their dignity and privacy.

- The wards had quiet areas for patients to sit and relax and areas specifically for meeting with visitors. These rooms could be booked to ensure availability during a visit. This was important at Mary Seacole House where space was more limited.
- All wards had small rooms equipped with a phone for patients to use in private. Patients on the acute wards had access to their own mobile phones. On Meadowcroft PICU, staff allowed the use of mobiles but these had to be kept in the office between calls.
- Patients had access to outside space. Most areas were quite spacious and had secure fencing.
- The quality of the food varied across the wards. While patients could choose from a menu at Mary Seacole House, where chilled food was delivered and reheated, patients reported that the quality was not good. At the Zinnia Centre, patients used a separate dining area off the wards and at the Oleaster site, food was brought to the wards and served to patients in dining areas on the wards. Patient led assessments of the care environment were self-assessments undertaken by teams of NHS and private/independent health care providers. This includes at least 50 per cent members of the public. The wards scored above the England national average of 91.9% for food with the lowest score being 98.9% for Mary Seacole House.
- Patients could access hot drinks and snacks 24/7 on the acute wards and staff provided these on request and regularly throughout the day on the PICUs.
- Bedrooms on the acute wards could be personalised and we saw that some patients had chosen to do this.
- Wards provided safes in rooms or lockers, which were in a locked room for patients' personal possessions. Staff logged patient's personal items during admission to the ward.
- Patients had access to activities such as art and crafts, activities of daily living, pool and a gym. There were fewer activities at weekends and some wards did not have an occupational therapist at the time of the inspection, which limited the activities on offer. Patients

in the acute wards at Oleaster were encouraged to use the wide range of activities available in The Venue, which was in the same building. The Venue provided therapeutic interventions such as art and music therapy and offered patients the opportunity to build life skills such as cookery. Staff from The Venue supported ward staff with escorted leave so that patients had access even when wards were busy.

Meeting the needs of all people who use the service

- Wards had access for people with physical disabilities including lifts where required. Wards at the Oleaster each had a high dependency bedroom and bathroom. On the other wards, except Eden PICU, a high dependency bathroom was available with hoists and specialised bath. On Ward 2 at Mary Seacole House the bathroom was not accessible to patients as it was being used for storage.
- All information leaflets on the wards were in English. Staff said leaflets in other languages were available on request although we did not see signs in other languages making this clear to patients. Information was included on how to complain, access to advocacy, information on mental health conditions and medication.
- Staff reported that it was easy to access interpreters and signers for people who were deaf.
- Staff reported that patients could order food such as halal to meet their dietary requirements.
- Patients had good access to spiritual support across all the wards. The chaplain was a regular visitor to the wards and supported patients to access support from their own faith. Wards tried to plan medication and mealtimes around religious customs where possible.

Listening to and learning from concerns and complaints

- Acute wards for adults of working age and psychiatric intensive care units received 27 complaints with one upheld (4%) during the 12 months from 01 December 2015 – 30 November 2016). No complaints were referred to the ombudsman. Meadowcroft PICU had the highest number of complaints with five across the 12-month period. The wards had received no formal compliments but all wards had displays of thank you cards and letters.

Are services responsive to people's needs?

Good 

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

- Patients knew how to complain and staff supported them to do this. Each ward had a complaints/compliments form and a box for these at the entrance to the ward for patients.
- The 'See Me' team and the peer support workers who were ex-patients employed by the trust both had a regular presence on the wards so patients could raise concerns at a very early point. The 'See Me' team facilitated community meetings on wards and could feed concerns back to the trust through governance meetings so patients felt they had been listened to.
- The wards received very few complaints but staff stated they received feedback after a complaint through supervision, handover or team meetings.

Are services well-led?

Good 

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

Our findings

Vision and values

- Staff knew the trusts values and could talk about them. They included honesty and openness, compassion, dignity and respect and commitment.
- The values formed part of supervision and appraisals and were an integral part of the Safe wards work that wards were engaging in and the team objectives.
- Staff knew who senior managers were and stated that local managers regularly visited the wards. Senior managers did not visit often but staff could name them. Three staff said that they felt disconnected from the senior management team and that decisions had been taken without consulting them or considering the impact on patients and their care.

Good governance

- Staff received mandatory training and had a compliance rate over 90%. Most staff received regular management supervision although when wards were busy or short staffed this was delayed. Managers said gaps in appraisals were because of staff sickness or new starters who had not yet received an appraisal.
- Wards had enough staff to cover shifts based on establishment figures but the due to the acuity of the patients, the high use of bank and agency staff, the blanket approach to searches on patients returning from Section 17 leave meant that qualified staff in particular stated they did not always have the time needed to focus on patient care.
- Each ward had access to an administrator who supported with these tasks so that staff could spend as much time as possible with patients.
- The level of audits completed varied across the wards with six wards doing this well and in others, we saw little evidence of audits being completed and managers stated this was something they were working towards starting. Audits of care plans had not picked up that there were gaps in the quality of recording by staff.
- Staff learned from incidents and complaints and all wards ensured learning across the team.

- Staff were confident about using safeguarding procedures and felt supported in this. Mental Health Act and Mental Capacity Act procedures were not robustly followed and there were gaps in the process and how they completed paperwork. HCAs stated that they would benefit from basic training in these areas.
- Wards used key performance indicators to manage performance and service development. These included training, sickness, delayed discharges and care planning.
- Ward managers said they had enough authority to do their jobs and felt well supported by their managers locally. Each ward had access to a ward administrator.
- Staff could submit items to the trust risk register through their managers. Staff had raised issues such as staffing levels and infection control relating to the number of domestic staff on each ward. Managers stated that by adding these to the trust risk register they had been fully resolved.

Leadership, morale and staff engagement

- The average maximum sickness rates for 12 months from December 2015 to November 2016 across the acute wards were 13.5% with Newbridge House having the highest maximum of 21%. The average maximum for PICUs was 6% with Caffra having the highest maximum at 11%. Managers stated that the sickness figures had been affected by staff being on long term sick leave which was being closely monitored and maternity leave. They had plans in place to support staff back into work and one staff member told us that she had been offered a change of working environment and shift patterns to facilitate this.
- There was one case of bullying and harassment disclosed during the inspection.
- Staff stated they felt confident that they could raise issues with managers if they needed to. They all knew the trust had a policy on how to whistle blow but did not feel they would need to use this.
- Staff morale on most wards was good despite the fact they felt under pressure due to staffing levels and the acuity of patients. On two wards, staff reported that this had affected morale which was low.

Are services well-led?

Good 

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

- Staff supported each other and gave examples of not wanting to move teams because of this. On all wards, staff spoke highly of their ward managers and the level of support they gave to the teams.
- Healthcare assistants had the opportunity to train to be band 4 associates. Staff felt opportunities were available if they wanted to progress in their careers. Staff stated they had the opportunity to take part in the trust's leadership programme.
- Staff gave examples of talking to patients and carers when things went wrong and managers encouraged a feeling of openness and transparency on all wards.

- Staff said they could give feedback on service development but felt that some consultations were a formality as decisions had already been made at a higher level in the trust.

Commitment to quality improvement and innovation

- Reservoir Court had received the accreditation for inpatient mental health service (AIMS) in December 2015.
- The trust had put together a positive, proactive, care panel. Their task was to create a five-year plan to reduce restrictive practice across forensic and adult inpatient services. This panel included consultants, ward manager, matrons, the AVERTS training manager and a senior clinical psychologist.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <ul style="list-style-type: none">• Newbridge House, Eden PICU, Eden Acute and George Ward had potential ligature points that had not been fully managed, mitigated, or addressed.• Newbridge House, Eden PICU, Eden Acute and George Ward wards had poor lines of sight. Staff could not easily observe patients.• Staff had not routinely recorded fridge temperatures on all wards.• Staff did not record routine searching of patients returning from section 17 leave in care plans and risk assessments and applied this as a blanket restriction to all patients rather than based on individual need. <p>This was a breach of Regulation 12 (1)(2) (a)(b)(d)(e)(g)</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>Regulation 11 HSCA (RA) Regulations 2014 Need for Consent</p> <ul style="list-style-type: none">• Staff had not fully completed capacity to consent to treatment forms and where they had they were not decision specific.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 11(1)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

- Staff had not completed fully section 17 leave paperwork and made this accessible to patients
- Staff had not reviewed section 62 paperwork and made timely referrals to SOAD.

This was a breach of Regulation 17 (2)(c)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA (RA) Regulations 2014 Safe Staffing

- Healthcare assistants did not receive MHA or MCA training which meant they could not fully support patients in this area.

This was a breach of Regulation 18 (2)(a)