Requires improvement

Pennine Care 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)
RT201	Irwell Unit	North ward	BL9 7TD
RT201	Irwell Unit	South ward	BL9 7TD
RT202	Tameside General Hospital	Saxon ward	OL6 9RW
RT202	Tameside General Hospital	Taylor ward	OL6 9RW
RT203	Parklands House	Northside ward	OL1 2JH
RT203	Parklands House	Southside ward	OL1 2JH
RT204	Birch Hill Hospital	Hollingworth ward	OL12 9QB
RT204	Birch Hill Hospital	Moorside ward	OL12 9QB

Summary of findings

RT205	Stepping Hill Hospital	Arden ward	SK2 7JG
RT205	Stepping Hill Hospital	Cobden unit Psychiatric Intensive Care Unit	SK2 7JG
RT205	Stepping Hill Hospital	Norbury ward	SK2 7JG

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	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** 

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

Contents

Summary of findings

Overall summary

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

- Three of the wards did not comply with same sex accommodation guidance which meant that patients' privacy and dignity may have been compromised.
- The layout and access to outside space on Northside and Southside wards did not ensure the safety, privacy and dignity of patients. Patients from Northside ward were only able to access outside space via Southside ward.
- We found that medicines practice was not always in line with current National Institute for Health and Care Excellence guidelines. There were three out of five rapid tranquilisation forms which we found to be missing or incomplete which meant that patient's physical health may not have been monitored. On two wards there were issues with the safe storage of medicines. The clinic room temperature on Cobden unit exceeded recommended guidelines and the fridge temperature on Southside and South ward was not monitored properly. Doctors did not always cancel medication records in line with trust policy.
- Patients were not always afforded privacy when receiving their medication.
- We found that training in basic life support and immediate life support did not meet trust targets on some wards.
- The trust had used the safer staffing tool to look at the staff required on each ward and to ensure patient safety. However, staff and patients told us that although there were enough staff they often had to deal with other tasks which sometimes took away time from their nursing role.
- There was a blanket restriction in place on all wards relating to cigarettes. These were removed from patients when they were admitted to the ward.
- We found that staff were not receiving supervision every four to six weeks as per trust policy. Not all members of staff had received an appraisal on a yearly basis as per trust policy. Staff sickness was above the national of average of 5% on eight of the wards which meant that bank and agency staff were used on a regular basis.
- There was very limited access to psychological therapies on wards and only Cobden unit had a ward based clinical psychologist. Moorside ward had a trainee clinical psychologist.
- Most of the patients we spoke to gave negative reports about the quality of food on the wards.
- We found some issues regarding Mental Health Act documentation. Recording of patients section 132 rights under the Mental Health Act was not always recorded and reviewed. In a small amount of files, we found that original Mental Health Act documentation was missing and capacity to consent to treatment was not recorded.
- There was high bed occupancy across all of the wards which led to patients waiting a considerable amount of time for their needs to be met. Patients told us that requests were not responded to quickly because the staff were so busy. On Norbury ward, the office door was closed and we saw that patients were queuing outside the door with requests which were not responded to in a timely manner.
- Patients did not always have a bed to return to upon return from leave. Continuity of care was disrupted as patients were sometimes admitted to a bed in other parts of the trust or out of area. This meant that patients were cared for by a different nursing team on a different ward.

However:

- Incidents of restraint and seclusion were low across all wards and we saw that there was good use of de-escalation techniques used across all wards. The trust had implemented the 'Safewards' model of care on all of the wards, which aimed to minimise conflict and maximise safety and recovery. The implementation of this approach had contributed to low levels of restraints and seclusion across all of the wards.

Summary of findings

- Patients felt involved in their care and attended weekly community meetings on the ward as part of the 'Safewards' initiative. They felt they were listed to in multidisciplinary meetings and were given choices in treatment options.
- The majority of staff treated patients with kindness, respect and dignity. Patients were oriented to the ward when they first arrived. There was good access to local advocacy services across all of the wards we visited and we found that advocates played an active role in patient care. Patients knew how to complain and were supported to do so. There was a full range of information leaflets available to patients and carers and these were displayed clearly on wards. Leaflets were available in different languages upon request.
- We were told and we observed good multidisciplinary working on all wards. Handovers and multidisciplinary meetings were detailed and comprehensive.
- Lessons learnt from incidents were shared with staff in variety of different ways including via emails, multidisciplinary team meetings and on an individual basis.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Three wards did not comply with same sex accommodation guidance.
- The layout and access to outside space on Northside and Southside wards did not ensure the safety, privacy and dignity of patients. Patients from Northside ward were only able to access outside space via Southside ward.
- Three out of five rapid tranquilisation monitoring forms were missing or not completed correctly.
- Staff were taken away from spending time with patients due to the level of need for care, high bed occupancy levels and the delegation of the bed management role to the wards out of hours.
- There were no individualised pharmacological strategies for using routine and when required medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression.
- On some wards trust targets for mandatory training including basic life support and immediate life support were not met.
- Doctors did not always follow trust policy when cancelling medicines on prescription charts.
- Patients did not always receive their medication on time which could have a negative impact on their well being and health. Medicines were not always stored safely. On one ward we found the temperature in the clinic room was above the recommended temperature. On two other wards the fridge temperature was not monitored properly.
- There were no mirrors to mitigate blind spots on Norbury, Southside and Northside wards.
- Patients were not always afforded privacy when receiving their medication.
- There was a blanket restriction in place on all wards relating to cigarettes. These were removed from patients when they were admitted to the ward.
- Patients did not always have a bed to return to upon return from leave. This meant that the continuity of care was disrupted as patients were sometimes admitted to a bed in other parts of the trust or out of area.

However:

- The seclusion room met the Mental Health Act code of practice requirements.

Summary of findings

- There were up to date ligature risk assessments on all wards we went to.
- The trust was implementing the 'Safewards' model of care whose aims were to reduce conflict and containment on wards and incidents of seclusion and restraint were low across all wards.
- There was good use of de-escalation techniques across all wards.
- All risk assessments we looked at were up to date.
- Staff demonstrated a good level of knowledge around safeguarding.
- Staff were able to give a clear explanation of Duty of Candour.
- There was good information sharing around incidents.

Are services effective?

Requires improvement 

We rated effective as requires improvement because:

- We found that supervision rates did not comply with trust policy. A high proportion of staff had not received supervision for several months whilst a small number of staff had not received supervision for up to two years.
- Appraisal rates on some wards did not comply with trust policy.
- There was limited access to psychological therapies on the majority of wards.
- We found that the recording and reviewing of patients section 132 rights under the Mental Health Act was not always completed in a timely manner.
- We found that copies of original Mental Health Act documentation were not always in the file.
- Care plans were not always personalised.

However:

- All patients had an up to date care plan.
- Staff were aware of National Institute for Health and Care Excellence guidelines.
- There were good physical healthcare checks across the wards we visited.
- There were regular multidisciplinary team meetings.
- There were detailed handovers completed at the change of every shift.
- Staff had a good understanding of the Mental Health Act.
- There was good access to Independent Mental Health Advocates across all wards.

Are services caring?

Good 

We rated caring as good because:

Summary of findings

- The majority of staff treated patients with kindness, respect and dignity.
- Patients were oriented to the ward on arrival.
- There was good access to local advocacy services.
- There was a full range of information leaflets available to patients and carers.
- Patients felt involved in their care and attended weekly community meetings on the ward.

However:

- Some patients told us they felt staff were too busy to listen to them.
- A small amount of patients said that staff had been rude to them or lacked compassion.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- There was high bed occupancy across all of the wards which led to patients waiting a considerable amount of time for their needs to be met. Patients told us that requests were not responded to quickly because the staff were so busy. On Norbury ward, the office door was closed and we saw that patients were queuing outside the door with requests which were not responded to in a timely manner.
- Patients did not always have a bed to return to upon return from leave. Continuity of care was disrupted as patients were sometimes admitted to a bed in other parts of the trust or out of area. This meant that patients were cared for by a different nursing team on a different ward.

However:

- Information leaflets were available to patients in a variety of different languages.
- There was good access to interpreters.
- Patients knew how to complain.
- Discharges were planned to ensure they were at an appropriate time for the patients and their carers.
- There were accessible bedrooms on the majority of wards for patients who had a physical disability.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

Summary of findings

- We found that supervision rates did not comply with trust policy. A high proportion of staff had not received supervision for several months whilst a small number of staff had not received supervision for up to two years.
- Appraisal rates on some wards did not comply with trust policy.
- Three out of five rapid tranquilisation monitoring forms were missing or not completed correctly.
- Staff were taken away from spending time with patients due to the level of need for care, high bed occupancy levels and the delegation of the bed management role to the wards out of hours.
- Three wards did not comply with same sex accommodation guidance.
- On some wards trust targets for mandatory training including basic life support and immediate life support were not met.

However:

- Staff reported that managers were supportive and visible on the wards.
- There were monthly ward managers meetings to enable them to discuss issues affecting the ward
- Staff undertook clinical audits.
- There were opportunities for leadership development for ward managers.
- The ward team were able to submit items to the trust risk register.

Summary of findings

Information about the service

Pennine Care NHS Foundation Trust had10 acute wards across five hospitals for adults who required hospital admission due to their mental health needs. Some of the patients were detained under the Mental Health Act 1983.

The acute wards were all mixed gender wards and comprised:

- North ward. This was a 24 bed ward at the Irwell Unit, Bury.
- South ward. This was a 24 bed ward at the Irwell Unit, Bury.
- Saxon suite. This was a 23 bed ward at Tameside General Hospital, Ashton-under-Lyne.
- Taylor ward. This was a 22 bed ward at Tameside General Hospital, Ashton-under-Lyne.
- Northside ward. This was a 22 bed ward at Parklands House, Rochdale.
- Southside ward. This was a 22 bed ward at Parklands House, Rochdale.
- Hollingworth ward. This was a 21 bed ward at the John Elliott Unit, Rochdale.
- Moorside ward. This was a 21 bed ward at the John Elliott Unit, Rochdale.
- Arden ward. This was a 24 bed ward at Stepping Hill Hospital, Stockport.
- Norbury ward. This was a 23 bed ward at Stepping Hill Hospital, Stockport.

These wards were managed by the trust's acute adult mental health services division.

Pennine Care NHS Foundation Trust also had a ward which provided an intensive care service for people who required increased levels of observation and support.

This ward was:

- Cobden unit. This was a ten bed ward for males at Stepping Hill Hospital, Stockport.

Cobden unit was managed and led by the low secure and rehabilitation services. The staffing structure, supervision model, training and governance of the service was provided by the specialist services division.

This inspection was the first one under the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Our inspection team

Our inspection Team was led by:

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

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharron Haworth, Inspection Manager, Care Quality Commission

The team inspecting acute wards for people of working age and psychiatric intensive care units comprised: two CQC inspectors, one consultant psychiatrist, one specialist registrar, one social worker, two registered mental health nurses, one mental health act reviewer, two pharmacists, one assistant inspector and one business systems analyst.

Due to the number of acute wards, the team split into two sub teams. One of the sub-teams inspected five acute wards and the psychiatric intensive care unit. The other sub team inspected five acute wards.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited all 11 of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with 44 patients who were using the service
- Spoke with the managers for each of the wards
- Spoke with 45 other staff members; including doctors, nurses, occupational therapists and nursing assistants
- Looked at 60 care records
- Spoke to six carers
- Attended and observed four handover meetings and three multidisciplinary meetings
- Carried out a specific check of the medication management on four wards and reviewed 129 prescription charts
- Looked at 56 supervision and appraisal records
- Carried out a specific check of the medication management on four wards
- Observed one meal time
- Observed one occupational therapy group

Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 44 patients during our visit and also attended focus groups for patients. The majority of patients said that staff treated them with kindness, dignity and respect. However, three patients said that staff did not have time to listen to them as the wards were busy. Two patients said that on occasion staff had been rude to them. Two patients said that staff spent a lot of time in the office.

Patients said they had seen complaints information and could ask a member of staff if necessary. On some wards patients said that there were plenty of activities to do but on other wards they said that there wasn't much to do. Patients said that they found the weekly community meetings helpful and they felt they could speak about any concerns at these meetings.

Most patients gave negative comments about the food available to them. Some patients said that the food was cold by the time they got to it, that it did not taste nice nor look appetising. Some patients said there wasn't much choice but others said there was enough choice. Patients on the majority of wards we went to said that there was no access to snacks in between meal times. Overall, patients said that the ward environments were clean and tidy.

Summary of findings

We spoke to six carers and also attended focus groups for carers. Carers commented on the level of need for care on the wards which sometimes made their relatives who were on the ward feel unsafe. They said sometimes there were no beds near to where they lived which made visits more difficult. Other carers we spoke to said that staff were 'brilliant', kind and considerate toward them and had a good understanding of their relatives' needs. They were happy with the cleanliness of the ward.

Good practice

The trust had implemented the 'Safewards' model of care on all of the wards, which aimed to minimise conflict and maximise safety and recovery. Wards held community meetings on at least a weekly basis and the agenda for the meetings included a round of thanks, suggestions for improvement and offers of help and a debrief of the previous weeks incidents. The implementation of this approach had contributed to low levels of restraints and seclusion across all of the wards.

The trust had introduced a 'know each other' board which provided patients with key information about staff and their role on the ward.

A pharmacist provided a weekly session for inpatients on Hollingworth and Moorside wards. This enabled patients to ask about their medication and any concerns that they may have. It was a group session but patients could also speak to the pharmacist individually.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that clinical staff meet the needs of patients and respond to requests by patients in a timely manner.
- The trust must ensure that all care plans are personalised.
- The trust must ensure that all wards are compliant with the Department of Health guidance on same sex accommodation in order to ensure the safety, privacy and dignity of patients.
- The trust must ensure that the layout of the wards and access to outside space ensures the safety privacy and dignity of patients.
- The trust must ensure that all wards comply with national guidelines and trust policy on rapid tranquilisation. Physical observations must be monitored following rapid tranquilisation on the approved form and within the correct timescales.
- The trust must ensure that staff follow trust policy when cancelling a medicine on a patient's chart.
- The trust must ensure that fridge temperatures are properly monitored and maintained.
- The trust must ensure that the temperature in clinic rooms is within recommended guidelines.
- The trust must ensure that medications are administered and recorded as prescribed.
- The trust must ensure that staff receive supervision in line with trust policy.
- The trust must ensure that mandatory training reaches trust targets in all areas.
- The trust must ensure that the continuity of care for patients is maintained and patients are not routinely moved wards or areas during their period of admission.

Action the provider SHOULD take to improve

- The trust should ensure that patients detained under the Mental Health Act 1983 are read their rights regularly and original detention papers are placed in patients' care records.
- The trust should consider the use of mirrors to mitigate blind spots on the wards where they were missing.
- The trust should ensure that patients are afforded privacy when receiving medication.

Summary of findings

- The trust should ensure that all staff have an annual appraisal.
- The trust should ensure that any restrictions placed on patients are based on individual risk assessments. This includes restrictions around smoking. The trust should ensure that section 17 escorted leave is facilitated by staff and adhered to.
- The trust should ensure that the food is of a good quality and that patients have access to snacks at all times.
- The trust should ensure that there is an individualised pharmacological strategy for using routine and when required medication in line with best practice guidance.
- The trust should consider the development of psychological therapy programmes across all wards.

Pennine Care 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
North ward South ward	Irwell Unit
Saxon ward Taylor ward	Tameside General Hospital
Northside ward Southside ward	Parklands House
Hollingworth ward Moorside ward	Birch Hill Hospital
Arden ward Cobden unit Psychiatric Intensive Care Unit Norbury Ward	Stepping Hill Hospital

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.

At the time of inspection 81% of staff across all acute wards and the psychiatric intensive care units had completed training in the Mental Health Act, although this was not mandatory. This included training in the revised Mental Health Act Code of Practice. Staff demonstrated that they had a good understanding of the Mental Health Act.

Detailed findings

There was one seclusion unit in the trust which was located at Cobden unit, the psychiatric intensive care unit in Stockport. We found that the seclusion room and the documents we examined were compliant with the Mental Health Act code of practice.

A Mental Health Act reviewer looked at 14 files of patients who were detained under the Mental Health Act. We found that the majority of patients' rights under section 132 of the Mental Health Act were regularly revisited and reviewed.

We found that independent mental health advocates played an active role on all wards. Patients were automatically referred to the service if they were deemed not to have capacity. Patients told us advocates were supportive of them. Independent mental health advocates we spoke to said that staff were understanding and accepting of their role.

The mental health act administration department provided good support to ward staff and there were robust systems in place.

On all of the wards we visited there was visible signage near the exit doors advising informal patients of their right to leave the ward.

We looked at 129 prescription charts and found that there were no discrepancies between patients' prescribed medicines and documentation required by mental health legislation (T2, T3 and section 62 forms) in the majority of records we looked at. Responsible clinicians had recorded an assessment of the patient capacity to consent.

In two of the records we looked at there were no copies of patients' original detention documents. In two records we looked at there was no approved mental health professional report present.

The majority of forms we looked at for section 17 leave under the Mental Health Act were present and completed correctly. However one section 3 patient was in the general hospital receiving physical health care and had been for three days with no section 17 completed. The responsible clinician rectified this whilst we were on the ward.

There were blanket restrictions around patients handing in their cigarettes on admission. They said that they often got mixed up and the wrong ones were given out which caused distress. All patients had access to personal mobile phones but chargers were kept in the nursing office. However, the trust told us that cigarettes and lighters were removed from patients when they were admitted to reduce the fire risk to staff, patients and property.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection 81% of staff across all acute wards and the psychiatric intensive care unit had completed training in the Mental Capacity Act. The staff we spoke to had a basic understanding of the Mental Capacity Act.

There were no patients detained under the Deprivation of Liberty safeguards and there were no pending applications.

The trust had a Mental Capacity Act policy that the staff could refer to if necessary. The Mental Health Act administrator could offer advice and guidance.

We saw examples of two best interests assessments where there had been decisions around the residence of one patient and the physical health of another patient.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

The layout of some of the wards meant that they did not allow clear lines of sight which obstructed staff observations. On Norbury, Moorside, Southside and Northside wards there were no mirrors in place to mitigate against the risk of incidents. However, nursing staff checked the ward environment every 15 minutes as well as completing patient observations to ensure patient safety.

There were ligature points on all of the wards we went to. A ligature point is a place to which patients intent on harming themselves might tie something to strangle themselves. We saw that ligature risk assessments had been completed and were up to date for all wards. These identified ligature points on the wards and included action plans for completion by the relevant department. All bathrooms and bedrooms were fitted with anti-ligature furniture apart from the accessible bedrooms for those with mobility difficulties. Patients at risk of self harm were not given an accessible bedroom. Nursing staff conducted regular environment checks and patient observations. Curtain rails were anti-ligature. Rooms that presented as a ligature risk were always locked.

All of the acute wards were mixed gender. Three of the wards, Northside and Southside and Hollingworth, did not comply with the Department of Health guidance on same sex accommodation. We observed that male and female patients were in bedrooms next to each other on Southside and Northside wards. On Hollingworth ward females had to go through a male corridor to use the designated female bathroom. This meant that patients' privacy and dignity may have been compromised as males had to pass female rooms to access other parts of the ward and vice versa. On Norbury ward the door that led to the female corridor was left open which meant male patients could access the female bedroom area, however we were assured that this was usually shut. All of the other acute wards we visited met same sex accommodation guidance with separate male and female bedroom areas and female only lounges.

Clinic rooms on all wards were fully equipped apart from on Taylor ward, where there was no examination couch. Staff explained and we observed that there was no space for an examination couch in the room which meant that patients had to go to their bedroom if they were required to lie down for an examination. We saw that resuscitation equipment was accessible and regularly checked. Emergency drugs were checked regularly, these were all up to date and were easily accessible. All of the clinic rooms we looked at were clean and well maintained. On Cobden unit, the temperature inside the medicines cupboard was above the maximum recommended temperature of 25 degrees centigrade. Staff were aware of this and had requested that the clinic should be moved to another room, however there was no specific time frame for when this would be completed. On South ward and Southside ward the medicines refrigerator records showed that the temperature was occasionally below the set minimum of two degrees centigrade. This meant that the safety and effectiveness of some medicines could be adversely affected.

There was a seclusion room on Cobden unit which was compliant with the Mental Health Act Code of Practice. There was a toilet and shower facilities in the room. The room allowed for two way observation and had a clock to enable patients to remain oriented to time. There was an intercom to provide communication with the patient. Furnishings included a bed, mattress, pillow and blanket. There were no apparent safety hazards. There was a window which provided natural light. Lighting was controlled by staff and had subdued lighting for night time. The doors were robust and opened outwards. The room temperature was controlled externally by staff. There were no blind spots in the room.

All of the wards we inspected were clean and well maintained with good furnishings. We observed domestic staff cleaning wards. Cleaning records were up to date and demonstrated that the wards were regularly cleaned. However, on Moorside ward there were no cleaning records held on the ward. Patient Led Assessment of the Care Environment in relation to cleanliness for all of the wards were in a range of scores over 99% in 2015.

Requires improvement

Are services safe?

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

There were hand sanitisers on all of the wards and all of the entrances to wards. We observed that staff used these at appropriate times. Staff had recently been allocated uniforms to wear which ensured that all staff were bare below the elbow.

There were nurse call systems and appropriate alarms on all wards. On Arden and Norbury ward a new system had been implemented which used fingerprint technology to ensure extra security and an electronic audit trail of keys and alarms.

Safe staffing

Bank and agency staff usage in last three months up to 31 May 2016:

North ward

Establishment levels whole time qualified nurses 13

Establishment levels whole time nursing assistants 16

Number of whole time vacancies qualified nurses 2

Number of whole time vacancies nursing assistants 1

Number of shifts filled by bank or agency staff 144

Number of shifts not filled by bank or agency staff 13

South ward

Establishment levels whole time qualified nurses 14

Establishment levels whole time nursing assistants 16

Number of whole time vacancies qualified nurses 4

Number of whole time vacancies nursing assistants 1

Number of shifts filled by bank or agency staff 118

Number of shifts not filled by bank or agency staff 13

Saxon suite

Establishment levels whole time qualified nurses 12

Establishment levels whole time nursing assistants 18

Number of whole time vacancies qualified nurses 4

Number of whole time vacancies nursing assistants 6

Number of shifts filled by bank or agency staff 161

Number of shifts not filled by bank or agency staff 6

Taylor ward

Establishment levels whole time qualified nurses 12

Establishment levels whole time nursing assistants 19

Number of whole time vacancies qualified nurses 4

Number of whole time vacancies nursing assistants 4

Number of shifts filled by bank or agency staff 168

Number of shifts not filled by bank or agency staff 9

Northside ward

Establishment levels whole time qualified nurses 12

Establishment levels whole time nursing assistants 16

Number of whole time vacancies qualified nurses 2

Number of whole time vacancies nursing assistants 1

Number of shifts filled by bank or agency staff 163

Number of shifts not filled by bank or agency staff 13

Southside ward

Establishment levels whole time qualified nurses 14

Establishment levels whole time nursing assistants 16

Number of whole time vacancies qualified nurses 2

Number of whole time vacancies nursing assistants 3

Number of shifts filled by bank or agency staff 166

Number of shifts not filled by bank or agency staff 14

Hollingworth ward

Establishment levels whole time qualified nurses 11

Establishment levels whole time nursing assistants 13

Number of whole time vacancies qualified nurses 3

Number of whole time vacancies nursing assistants 2

Number of shifts filled by bank or agency staff 185

Number of shifts not filled by bank or agency staff 29

Moorside ward

Establishment levels whole time qualified nurses 14

Establishment levels whole time nursing assistants 17

Number of whole time vacancies qualified nurses 2

Number of whole time vacancies nursing assistants 1

Requires improvement

Are services safe?

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

Number of shifts filled by bank or agency staff 104

Number of shifts not filled by bank or agency staff 46

Arden ward

Establishment levels whole time qualified nurses 13

Establishment levels whole time nursing assistants 22

Number of whole time vacancies qualified nurses 1

Number of whole time vacancies nursing assistants 3

Number of shifts filled by bank or agency staff 179

Number of shifts not filled by bank or agency staff 27

Cobden unit

Establishment levels whole time qualified nurses 15

Establishment levels whole time nursing assistants 14

Number of whole time vacancies qualified nurses 4

Number of whole time vacancies nursing assistants 3

Number of shifts filled by bank or agency staff 132

Number of shifts not filled by bank or agency staff 10

Norbury ward

Establishment levels whole time qualified nurses 14

Establishment levels whole time nursing assistants 18

Number of whole time vacancies qualified nurses 3

Number of whole time vacancies nursing assistants 1

Number of shifts filled by bank or agency staff 181

Number of shifts not filled by bank or agency staff 23

Staff sickness rates and turnover over the past 12 months up to 31 May 2016:

North ward

Total number of substantive staff 29

Total number of substantive staff leavers in the past 12 months 3

Total % vacancies (excluding seconded staff) 11%

Total % permanent staff sickness 6%

South ward

Total number of substantive staff 24

Total number of substantive staff leavers in the past 12 months 1

Total % vacancies (excluding seconded staff) 18%

Total % permanent staff sickness 5%

Saxon suite

Total number of substantive staff 25

Total number of substantive staff leavers in the past 12 months 1

Total % vacancies (excluding seconded staff) 33%

Total % permanent staff sickness 9%

Taylor ward

Total number of substantive staff 27

Total number of substantive staff leavers in the past 12 months 1

Total % vacancies (excluding seconded staff) 29%

Total % permanent staff sickness 12%

Northside ward

Total number of substantive staff 27

Total number of substantive staff leavers in the past 12 months 1

Total % vacancies (excluding seconded staff) 12%

Total % permanent staff sickness 8%

Southside ward

Total number of substantive staff 30

Total number of substantive staff leavers in the past 12 months 1

Total % vacancies (excluding seconded staff) 16%

Total % permanent staff sickness 8%

Hollingworth ward

Total number of substantive staff 20

Total number of substantive staff leavers in the past 12 months 0

Total % vacancies (excluding seconded staff) 20%

Total % permanent staff sickness 7%

Requires improvement

Are services safe?

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

Moorside ward

Total number of substantive staff 29

Total number of substantive staff leavers in the past 12 months 1

Total % vacancies (excluding seconded staff) 10%

Total % permanent staff sickness 3%

Arden ward

Total number of substantive staff 31

Total number of substantive staff leavers in the past 12 months 1

Total % vacancies (excluding seconded staff) 12%

Total % permanent staff sickness 10%

Cobden unit

Total number of substantive staff 22

Total number of substantive staff leavers in the past 12 months 0

Total % vacancies (excluding seconded staff) 24%

Total % permanent staff sickness 4%

Norbury ward

Total number of substantive staff 32

Total number of substantive staff leavers in the past 12 months 0

Total % vacancies (excluding seconded staff) 14%

Total % permanent staff sickness 13%

Staff sickness rates were above the national average of 5% on all wards except North ward, Moorside ward and Cobden unit. The trust were committed to recruiting staff and there was an ongoing recruitment programme, however there were ongoing difficulties in this area due to national issues with the recruitment of nursing staff.

The trust used the NHS England safer staffing initiative to establish levels of staffing required on each ward. We observed that staffing levels were written on a board outside of each ward we visited. Where there were vacancies or staff sickness, there was appropriate use of bank or agency staff. Wards managers told us that wherever possible they used bank staff that were familiar with the ward environment and patients' needs. There was a trust induction checklist that was used when new staff started which included a tour of the ward. This enabled staff to familiarise themselves with the clinic room, emergency equipment, patient areas and bedrooms.

All wards managers assured us that they were able to adjust staffing requirements at times of greater level of need for care of patients.

We observed and were told that an experienced member of staff was present in communal areas of the ward at all times.

Patients and staff on some wards told us that on occasion section 17 escorted leave was delayed or cancelled due to levels of need for patient care on the ward. The trust told us that they did not record incidences of leave being cancelled on any of the acute wards. Activities on the ward were occasionally cancelled due to annual leave or sickness and we were told that where possible activities were rescheduled.

Mandatory training for staff in the trust was:

- corporate induction
- health and safety level one
- child safeguarding level one
- basic life support
- immediate life support
- infection control level one
- moving and handling level one
- equality and diversity
- adult safeguarding level one
- conflict resolution level one
- information governance level one
- preventing violent extremism
- fire safety level one.

The trust target for mandatory training was 95% apart from preventing violent extremism training which was 85% and immediate life support which was 60%. All courses were three yearly with the exception of corporate induction which was once at commencement of employment and

Requires improvement

Are services safe?

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

basic life support, immediate life support, information governance and fire safety which were annual. Average mandatory training compliance for each ward was as follows:

- North ward 93%
- South ward 92%
- Saxon suite 83%
- Taylor ward 77%
- Northside ward 90%
- Southside ward 96%
- Hollingworth ward 86%
- Moorside ward 84%
- Arden ward 93%
- Cobden unit 100%

Norbury ward 90%.

Data provided by the trust up to April 2016 showed levels of compliance below 75% in the following areas:

North ward

Basic life support 74%

Hollingworth ward

Immediate life support 25%

Saxon suite

Information governance level one 70%

Basic life support 60%

Immediate life support 56%

Taylor ward

Moving and handling level one 74%

Fire safety level one 52%

Basic life support 72%

Ward managers were aware of shortfalls in training and we saw they had developed good methods to monitor staff compliance, including colour coded spreadsheets indicating whether training was in date, needed to be updated, or was overdue.

Assessing and managing risk to patients and staff

Incidents of seclusion and restraint were low compared to other NHS trusts.

The trust was implementing the 'Safewards' model of care. This came from the Department of Health guidance on Positive and Proactive care published in 2014. Its aims were to reduce conflict and containment within psychiatric settings, in particular the use of restraint. We heard staff using positive words about patients at handovers. Staff used verbal de-escalation techniques to reduce conflict. There were weekly community meetings for patients to enable them to share any comments with regard to any issues they had. We saw minutes from weekly meetings and saw that a round of thanks from staff to patients was given. All ward managers we spoke to ensured us that least restrictive practices where used at all times and restraint was only used when all other techniques had failed.

Incidents of seclusion and restraint in the three months leading up to 31 May 2016:

North ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 13

Of the incidents of restraint how many were incidents of prone restraint? 5

How many of the prone restraints resulted in rapid tranquilisation? 5

South ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 7

Of the incidents of restraint how many were incidents of prone restraint? 2

How many of the prone restraints resulted in rapid tranquilisation? 2

Saxon suite

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 11

Of the incidents of restraint how many were incidents of prone restraint? 4

Requires improvement

Are services safe?

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

How many of the prone restraints resulted in rapid tranquilisation? 4

Taylor ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 18

Of the incidents of restraint how many were incidents of prone restraint? 2

How many of the prone restraints resulted in rapid tranquilisation? 2

Northside ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 13

Of the incidents of restraint how many were incidents of prone restraint? 2

How many of the prone restraints resulted in rapid tranquilisation? 2

Southside ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 10

Of the incidents of restraint how many were incidents of prone restraint? 2

How many of the prone restraints resulted in rapid tranquilisation? 2

Hollingworth ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 1

Of the incidents of restraint how many were incidents of prone restraint? 0

How many of the prone restraints resulted in rapid tranquilisation? 0

Moorside ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 15

Of the incidents of restraint how many were incidents of prone restraint? 2

How many of the prone restraints resulted in rapid tranquilisation? 1

Arden unit

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 4

Of the incidents of restraint how many were incidents of prone restraint? 0

How many of the prone restraints resulted in rapid tranquilisation? 0

Cobden unit

Number of incidents of use of seclusion 2

Number of incidents of use of restraint 18

Of the incidents of restraint how many were incidents of prone restraint? 2

How many of the prone restraints resulted in rapid tranquilisation? 2

Norbury ward

Number of incidents of use of seclusion N/A

Number of incidents of use of restraint 30

Of the incidents of restraint how many were incidents of prone restraint? 7

How many of the prone restraints resulted in rapid tranquilisation? 7

The trust used the trust approved risk assessment document. We looked at the care records of 60 patients and saw that all of the risk assessments were up to date and comprehensive. We saw that these had been updated on a weekly basis and after incidents.

There was a blanket rule regarding smoking on all wards. Patients could go out every hour or every two hours depending on the ward. Patients weren't allowed to keep their own cigarettes. We saw patients queueing up at the door to the courtyard on Norbury ward whilst a nurse lit their cigarettes one at a time. This compromised patients dignity. However, the trust told us that cigarettes and lighters were removed from patients when they were admitted to reduce the fire risk to staff, patients and property.

Requires improvement

Are services safe?

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

All of the wards we went to were locked. In the case of informal patients, we saw that there were signs near to the exit doors that detailed informal patients' right to leave the ward and the procedure for doing so. Informal patients we spoke to were aware of their right to leave and this was also documented in care plans for informal patients.

There were good policies in place for use of observation. We observed that staff completed a range of observations of patients and the ward environment as a whole. These were completed in a discreet manner.

There was a searching patients policy. Patients and their belongings were routinely searched when they were first admitted to the ward to ensure that there were no items that could present a risk to the patient or other people. However, after this patients were not searched unless a risk had been identified.

We looked at 129 prescription charts on across all wards. We found that the charts were clearly presented and there was evidence of pharmacist's checks and notes. Records showed that patients had the opportunity to discuss their medicines with the doctor and the use of 'when required' medicines was reviewed at ward rounds as recommended in National Institute for Health and Care Excellence guidelines. However, pharmacological care plans were not in place describing the use of 'when required' medicines. We spoke with two nurses about this. The nurses explained that this had been highlighted by the consultant psychiatrist and that a teaching session on consistency and use of 'when required' medicines was planned. National Institute for Health and Care Excellence guidelines NG10 recommends that patients have a documented individualised pharmacological strategy for using routine and when required medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression.

Two of the records we looked at on North ward showed that patients had received rapid tranquilisation. Nurses had clearly detailed these incidents in the patients' nursing notes. However, for three of the five incidents of rapid tranquilisation, nurses were unable to locate the monitoring form and for one of the monitoring forms monitoring was recorded correctly for first 4 hours, but then stopped. This meant it was not always possible to confirm that nurses had appropriately monitored the patients' physical health after the use of rapid tranquillisation.

We found that doctors did not always follow trust policy when cancelling medicines on patients' charts on Southside ward. We found that patient charts had not been clearly struck through or signed and dated. This was unsafe practice as the prescriber's instruction may be misread. We found no discrepancies between patients' prescribed medicines and documentation required by mental health legislation (T2, T3 and section 62 forms).

The nurses' administration records were mostly complete, indicating that patients were receiving their medicines as prescribed. However, missing signatures on one chart meant on Southside ward that the patient had missed up to seven doses of their anticoagulant medicine over a period of 15 days. This had not been reported as an incident, despite the risk to the patient's health. Another patient on Southside ward had been given their once weekly injection to treat diabetes 56 hours late on one occasion.

Records showed that patients had the opportunity to discuss their medicines with the doctor and the use of 'when required' medicines was reviewed at ward rounds. This was in accordance with guidance in the National Institute for Health and Care Excellence Guideline NG10: Violence and aggression: The short term management in mental health, health and community settings.

We saw evidence that patients prescribed high doses of anti-psychotic medicines were protected from the risks of harmful adverse effects. The trust had an integrated care pathway document for managing the care of patients taking clozapine. The trust's guidelines for the initiation and monitoring of high dose antipsychotic therapy clearly stated the roles and responsibilities of medical, nursing and pharmacy staff.

Appropriate arrangements were in place for managing controlled drugs. Stock levels of the sample of controlled drugs we checked were correct.

We observed patients being given their medicines on two wards, Arden and Southside. Staff administered medicines in a friendly way, following the trust's procedure for checking that patients received the right medicine. On Southside ward, patient confidentiality was not respected due to patients queuing closely to each other. There was a risk that patients waiting for their medicines could access the medicines trolley as this was located close to the clinic room door.

Requires improvement

Are services safe?

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

Pharmacy staff compiled an up to date list of patients' medicines within 24 hours of admission from Monday to Friday. The pharmacist on-call for the acute trust could be contacted out of hours.

A pharmacist provided a weekly session for inpatients on Hollingworth and Moorside wards. This enabled patients to ask about their medication and any concerns that they may have. It was a group session but patients could also speak to the pharmacist individually.

There was one seclusion room in the trust at Cobden unit. This was for male patients only. We completed a review of the seclusion unit on Cobden and observed a patient being cared for in seclusion. We found that seclusion was used appropriately, comprehensive records were kept and the use of seclusion followed best practice guidance in accordance with the Mental Health Act Code of Practice.

Levels of safeguarding training across all acute wards and psychiatric intensive care units in the trust up to 31 May 2016 ranged from 86% to100% for adult safeguarding level one and 87% to100% for child safeguarding level one. All of the staff we spoke to demonstrated a high level of knowledge about safeguarding. They were aware of how to make a safeguarding alert and what to do if they witnessed any incident of alleged abuse. Some ward managers were designated safeguarding leads and had been involved in safeguarding investigations. There was a safeguarding lead for the trust who staff were familiar with and who they could contact if they needed any guidance on safeguarding.

There were designated family visiting rooms at each of the locations we visited. The family room shared by Northside and Southside ward was in the reception area and was a thoroughfare for patients passing in between the two wards, however the door to this family room was lockable. All of the family visiting rooms we saw were brightly decorated and were equipped with children's toys. Patients were assessed prior to children visiting to ensure childrens' safety.

Track record on safety

From 1 June 2015 to 31 May 2016 there were 72 serious incidents across the 11 wards. On Cobden unit, there were three reported serious incidents. There were two reported medication errors that resulted in patients being given the wrong drugs and one incident in relation to the administration of the Mental Health Act.

On the adult acute wards there were a total of 69 incidents that were reported as serious incidents. These included 11 self-harm incidents, eight reported medication errors, four reported assaults to patients by patients, four unexpected deaths, four violence and aggression incidents, two reported assaults to staff. There were 21 reported incidents of administration of the Mental Health Act errors. All Mental Health Act errors were classified as a level four incident and therefore reported as serious.

Reporting incidents and learning from when things go wrong

All staff had access to the electronic incident reporting system used by the trust. This was called the 'safeguard' system. They were aware of how to report incidents on the system.

From 1 June 2015 to 31 May 2016 there were 2165 incidents in total across all acute wards and the psychiatric intensive care unit. Norbury ward had the highest number of incidents with 418 and Saxon suite the lowest number with 120.

Staff we spoke to were able to give a clear explanation of Duty of Candour. Duty of Candour is a statutory requirement to ensure that providers are open and transparent with people who use services in relation to their care and treatment. It sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. We saw evidence of staff offering support and apologising to patients and their families when things went wrong. The trust incident reporting system ensured that the Duty of Candour requirements were met as staff could only close the incident once all Duty of Candour actions had been taken.

Staff told us that they received feedback from investigations into incidents by email, attendance at staff meetings or the staff forum and in group or individual supervision. In addition, any governance reviews were sent to the ward detailing any shared learning from investigations. This information was placed on a noticeboard in the nursing office and also in a staff file. Ward managers told us that staff were debriefed after a serious incident and this was recorded in the incident review form. However we were told that there was no separate form for recording debriefs. Staff were given the

Requires improvement

Are services safe?

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

opportunity to go home after cover had been found after serious incidents and they could be provided with extra support from the staff wellbeing service provided by the trust. Managers maintained contact with staff if they were off work after a serious incident.

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 reviewed 60 sets of care records, all of which had an up to date care plan in place. Care records were completed when a patient was first admitted onto the ward. We found that across all wards there was good physical health monitoring in place. For one patient on Arden ward, staff ensured that additional checks were in place and that staff from the acute trust visited on a weekly basis to monitor the patients' extra health care needs.

We found that all of the care plans we looked at contained a range of information but not all care plans were personalised or recovery oriented. There was a section for patient views on their care but in some care plans this contained general statements like 'currently consenting to admission'. Patient goals were more aimed at staff tasks to be completed on some care plans.

There were observation care plans and informal patient care plans ensure that patients were aware of their level of observation and their right to leave the ward.

Patient records were all kept in paper form in patient files. The trust did have an electronic recording system but inpatient units were not yet using this system to input patient notes and develop care plans. At the time of the inspection, only ward managers and ward clerks had been trained in the electronic recording system. We were told that if a patient was admitted out of hours, patients were assessed by mental health liaison or the crisis team prior to coming on the ward and this information was provided to the nursing staff on duty. If a patient was already known to mental health services, nursing staff requested any other information from the relevant team. We found that patient records were stored securely apart from on Northside ward. Patient notes were stored in a cupboard with a broken lock in the nursing office which meant that patient records could be accessed. However, the nursing office was locked and the ward manager contacted the estates department immediately and we were provided with written assurance that the cupboard would be fixed the next day.

Best practice in treatment and care

Pharmacy staff told us they participated in clinical audits, two examples being a trust wide antibiotic prescribing audit and the Prescribing Observatory for Mental Health lithium monitoring audit.

We saw that the trust had implemented guidance from the National Institute for Health and Care Excellence Guidelines on violence and aggression: The short term management in mental health, health and community settings when using intramuscular medication. Staff also followed guidelines on, psychosis and schizophrenia in adults, assessment and management of bi-polar disorder in adults children and young people and antenatal and postnatal mental health to ensure the safe care of a pregnant patient on one ward.

There was a ward based clinical psychologist on Cobden unit for two days per week but no dedicated psychologists on the other wards we visited. On Moorside ward there was a trainee clinical psychologist. On North ward a psychologist visited the ward to provide therapy to one patient with complex needs. On Cobden unit we were told that although patients could access individual therapy with the psychologist, their remit was to provide guidance to staff on delivering psychological therapies. There was also a clinical discussion group led by the psychologist on the unit that aimed to assist staff in developing formulations for patients.

On all of the wards we visited there were good physical health care checks in place. We observed and were given examples of when patients had accessed additional physical health care from within the trust.

Skilled staff to deliver care

There was a range of qualified and experienced staff on each ward. There were nurses, an occupational therapist and nursing assistants. A pharmacist visited the wards most days and provided support to staff. Consultant psychiatrists were not ward based but had patients who were allocated to them on each ward and could be contacted if necessary. Student nurses undertook placements on the ward. In addition there were domestic staff and administration staff on each ward. On some wards there were inclusion and recovery workers and on each ward there was a physical health lead.

There was a corporate induction and a local induction for new staff. All new starters, volunteers and bank staff received a one day corporate welcome session which included information on the trust as an organisation, principles of care and completed some mandatory training. The local induction involved regular meetings between

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.

ward managers and new staff. We saw a local induction checklist, used to ensure that all staff were well informed of protocols including sickness and absence reporting, working hours and governance.

The trust supervision policy stated that staff should receive management supervision every four to six weeks. Data provided by the trust indicated that on all acute wards supervision compliance was between ten and 20 percent. On Cobden unit, clinical supervision figures were not collected or recorded. However, the trust told us that they intended to develop a system to record supervision compliance. We looked at six supervision files and found that none had evidence of supervision as per trust policy. In total we looked at 56 supervision records across all wards and this confirmed that supervision compliance was low on the majority of wards we visited. We found some instances where supervision had not taken place for several months and in a small amount of cases staff had not received supervision for up to two years. Ward managers we spoke to acknowledged that staff were not always supervised in line with trust policy and said this was due to the busy nature of wards, high bed occupancy and the level of need for care. However we were told that there was a variety of informal supervision on the wards. Managers had an 'open door' policy and staff confirmed this. Clinical supervision had been in place on some wards including Taylor ward where there had been a clinical supervision group until April 2016. There was a clinical discussion group on Cobden unit where staff would be assisted to develop a formulation in relation to patients.

The data provided by the trust stated that the percentage of non-medical staff who had an appraisal over the last 12 months ranged from 59% on Taylor ward to 100% on Cobden unit. However, we looked at six staff files on Cobden unit and found that in two of these there was no appraisal documented. The trust told us that at the time of our inspection all appraisals had been completed and the two appraisals which we found to be missing from staff files were in the process of being typed and therefore were not present in the staff files. Of the 56 appraisal records we looked at across all wards, 40 had an up to date appraisal.

Staff told us that they could access specialist training including training on domestic abuse, phlebotomy, suicide prevention and substance misuse. One member of nursing staff on Saxon suite was on the degree pathway. There were nurse prescribers on some wards. Staff told us that the trust encouraged them to undertake specialist training.

There was a capability policy in the trust which enabled ward managers to address poor staff performance. Ward managers were able to describe and give examples of times when there had been staff performance issues and how they had supported staff to overcome these. Managers provided staff with additional support and supervision. We saw evidence in files that managers had met on a weekly basis with those staff who required additional support with action plans in place.

Multi-disciplinary and inter-agency team work

There were regular multidisciplinary team meetings on the wards. We observed four multidisciplinary meetings and found that the patients were involved in all aspects of the meeting including their discharge care planning and physical health care. All relevant disciplines had been invited and the meetings were well planned and informative. The day before the meeting a form had been filled out with the patient to ensure that their views were captured. Patients told us that this happened prior to their meetings.

We observed four handovers and found that these were effective. They were attended by all relevant disciplines. They discussed patients current risks and went into detail about any issues that needed to be raised. They were interactive and we observed that staff were attentive and asked relevant questions.

Staff told us that there were good working relationships with other teams. Care co-ordinators maintained contact with the wards on the whole and attended meetings where relevant. In particular there were good links with the local authority safeguarding teams.

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

Across all the wards, 81% of staff had completed training in the Mental Health Act. South ward, Arden ward, Norbury ward, Taylor ward and Cobden unit all achieved 100% compliance with training in the Mental Health Act. The ward where this was lowest was Hollingworth ward with 25%. Staff demonstrated that they had a good understanding of the Mental Health Act.

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.

A Mental Health Act reviewer looked at 14 records of people detained under the Mental Health Act. On Cobden unit the last two section renewal papers were in the patient file, but there were no copies of the patients' original section papers. Section 132 review of patients' rights documents were completed for May and June 2016, but there were no copies in the patient notes prior to this. A T3 certificate to authorise medication was in place dated 23 May 2016 and the responsible clinician had also completed an assessment of the patient capacity to consent to treatment on the same date.

On Norbury ward one patient was admitted to the general hospital receiving physical health care and had been for three days. There was no section 17 leave form completed. The responsible clinician rectified this whilst we were on the ward. One patient had been detained since 14 April 2016 and there was no evidence to see that section132 rights had been explained. Detention papers were all in order except for one patient who had no copies in their care record. This was rectified during our visit. There was inconsistent recording of assessment of patient capacity to consent to treatment on this ward. Section132 rights were regularly revisited and mostly signed by patient.

On North ward we examined four sets of patients' care records. All detention documents were present and in order. With two patients there were no Approved Mental Health Professional report in the notes. The responsible clinician had assessed patient capacity to consent to treatment either at first or most recent administration. We spoke to one patient who had been on the ward informally for some time. We asked her if she understood her right to leave the ward and she said that staff had told her that she did but staff had explained to her that due to her current level of risk they would ask for an assessment under the Mental Health Act. The reviewing of section 132 rights were in date and the patient understood their rights. The responsible clinician had made a record that he had assessed the patient's capacity to consent to treatment.

On Moorside ward detention documents were all present in patient notes and appeared to be in order. Patients were aware of their rights under section 132. These were revisited monthly for patients detained under section three and weekly for patients detained under section two. The responsible clinician had made a note of the patient capacity to consent to treatment at the first or most recent administration of medication.

There was a mental health administrator who was centrally located in the trust. They assisted the wards in ensuring that weekly reports were sent to all wards. These reports detailed the section of the Mental Health Act the patient was detained under, section 132 rights that needed to be given to the patient and capacity to consent to treatment forms were completed.

On all of the wards we visited we saw that patients had access to independent mental health advocacy services. There were posters displayed on the wards that gave telephone numbers for the service. We were told that if a patient was deemed not to have capacity they were automatically referred to the independent mental health advocacy service. Patients told us that they saw the independent mental health advocate most days and all understood the role the independent mental health advocate played in supporting them. On Hollingworth ward we spoke with the independent mental health advocate who told us that staff were accepting and understanding of their role with patients.

Good practice in applying the Mental Capacity Act

Across all the wards, 81% of staff had training in the Mental Capacity Act.

Patients' capacity was assessed when needed. Staff assumed that patients had capacity. However we saw evidence that when patients were deemed not to have capacity, appropriate assessments were undertaken. We saw evidence of two best interests assessments that had been completed. These were around place of residence for one patient and physical health for another.

There were no Deprivation of Liberty safeguards applications made in the last six months. Staff we spoke to had a basic understanding of the Mental Capacity Act. Staff could access further advice and guidance from the Mental Health Act administrator.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke with 44 patients across all the wards we visited. The majority of patients said that staff were caring, polite, helpful and treated them with kindness and dignity. On Cobden unit we observed one patient who was in the seclusion room and saw that he was treated with dignity and respect by all staff present. On Hollingworth ward we observed interactions between staff and patients. We saw that staff undertook one to one observations in a respectful manner. We observed the ward psychiatrist in the communal area who knew all the patients. We observed one mealtime on Hollingworth ward and saw that the staff provided support in a relaxed manner. On Moorside ward, staff were polite and respectful. We observed one member of staff effectively de-escalate a situation by spending time listening to a patient and providing emotional support. On North ward we observed staff caring for patients in an exemplary manner. Staff were warm, friendly and polite. They responded quickly to patients and dealt with them sensitively. It was apparent that the staff on this ward knew the patients well and patients we spoke to confirmed this. We observed handovers and multidisciplinary team meetings and found that dignity, respect and compassion was demonstrated in the way staff communicated the patients' needs.

However, some patients said that staff did not listen to them and requests were not responded to quickly because the staff were so busy. On Norbury ward we observed that the majority of staff were in the office organising care rather than actively engaging with clients. The office door was closed and we saw that patients were queuing outside the office door with requests which were not responded to in a timely manner. Of the 44 patients we spoke with, seven patients spoke negatively about staff. On Arden ward, one patient told us that they did not feel listened to and one patient told us that some staff were less respectful than others. On Southside ward, one patient told us that staff did not listen and another patient told us that a member of staff was abrupt. On Cobden unit one patient told us that staff ignored them. Another patient on Taylor ward told us that some staff were ignorant. One patient on Norbury ward told us that one member of staff had been rude to them and although staff were polite, most of the staff lacked compassion.

Patient Led Assessment of the Care Environment are self-assessment scores undertaken by the NHS and include members of the public. The most recent patient led assessment of the care environment was undertaken in 2015. This found that the scores for privacy dignity and wellbeing on acute wards and psychiatric intensive care unit were above the England average of 86%. We were informed that the Patient Led Assessment of the Care Environment scores for 2016 had not yet been formally ratified so they were not available at the time of our inspection.

The involvement of people in the care that they receive

On admission, staff told us that patients were shown around the ward and shown where their bedroom was. We were shown written information that was given to patients upon their arrival which included visiting hours, meal times, times of cigarette breaks and community meetings. On Cobden unit we saw a detailed information pack for families and carers which included information on available treatments and therapies. Patients had been given the opportunity to choose colours and furnishings for Taylor ward during its refurbishment.

Details of local advocacy services were displayed on the wards and patients told us that they could access advocacy and had been supported to do so.

There were a range of noticeboards on the wards which provided information regarding what was safe, effective, caring, responsive, and well led and on the ward. The information included carers information, student information, how to make a complaint, how to contact CQC, information on 'Safewards', the 'getting to know each other board' which contained individual information about each staff member, the daily nurse allocation board and a therapeutic activities board.

We spoke to six carers who said that they felt that the staff did a great job under difficult circumstances. The majority of carers said that they had been involved in meetings about their relatives, however one carer said they had not been involved.

There were community meetings, at least weekly, on all wards for patients to share any comments or issues they had. We saw minutes from weekly meetings and saw that a round of thanks from staff to patients was given. On North ward there were two mutual help meetings held on the

Good

Are services caring?

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

ward. Each Wednesday the meeting included welcome to the ward, a round of thanks from staff to patients and suggestions about daily life on the ward and any incident de-briefs. The Sunday meeting was called 'that was the week' where patients were able to feedback about their care. We saw minutes of meetings called 'you said, we did' which demonstrated how the ward had acted on patient feedback. Patients on Moorside ward had requested more variety of food and staff had responded by informing senior management of this request. They had also requested more access to activities at weekends and as a result staff had started bingo and quiz sessions.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

Bed occupancy rates from 1 December 2015 to 31 May 2016 was over 85% for all wards. Cobden unit had the lowest bed occupancy rates at 85% and Saxon Suite the highest with 127%. North ward was 92%, South ward 123%, Northside ward 114%, Southside ward 107%, Hollingworth ward 99%, Moorside ward 93%, Taylor ward 116%, Arden ward 109%, and Norbury ward 107%. Research undertaken by the Royal College of Psychiatrists indicates that where wards are running at over 85% bed occupancy, this can have a negative impact on patient care. Patients on all wards were not always being provided with person-centred care due to high bed occupancy, the delegation of the bed management role out of hours and associated administrative tasks. This meant that staff were not always meeting the individual needs of patients in a timely manner.

There was a dedicated bed manager across north and south division from 9am to 5pm Monday to Friday for all acute wards, however there were different arrangements in place in each locality out of hours. In the north division which consisted of North, South, Northside, Southside, Hollingworth and Moorside wards, there was an out of hours bleep holder on the inpatient wards of one per borough. In the south division in Stockport there was a bed management rota which was shared between Norbury and Arden wards, the rapid assessment interface and discharge team, and home treatment. This was on a two month rotational basis. On Saxon and Taylor ward in Tameside, the bed management rota was managed by the wards out of hours. There was a night manager four nights per week in Tameside who had bed management responsibility. Staff on the wards told us that this impacted upon time spent on the ward with patients. On Cobden unit the responsibility for screening referrals was the responsibility of the senior management team based on the unit and the senior management team for rehabilitation and high support services. Out of hours the nursing team and the on call manager for rehabilitation and high support services screened referrals to Cobden unit.

Staff on all the wards we went to commented that there were constant pressures around bed availability. Patients who went on leave did not always have a bed to return to when they returned due to new patients being admitted to the ward. Patients were sometimes admitted to wards in another part of the trust or out of their local area which meant that they were unfamiliar with their local area and their families and carers had to travel many miles to visit them. On Norbury, North and Southside wards, staff told us that patients could be admitted to another borough if there was no bed available on return from leave. On Saxon, Taylor and Northside wards staff told us that there was not always a bed available when patients returned from leave, however the majority of the time there was a bed available. On South ward, staff told us that although beds were used when patients went on leave, staff would agree not to take new admissions if moving bedrooms would cause distress to the patient returning from leave. On Arden and Moorside wards, staff told us that it was rare that patients were admitted to another ward or out of area bed on return from leave. From 15 March 2016 to 16 June 2016 there were seven females and five males from the psychiatric intensive care unit admitted to beds out of area. In the past six months there was one patient from the acute wards admitted to an out of area bed overnight and then returned to a ward in the trust.

Where transfer to the psychiatric intensive care unit was required, this was sometimes delayed due to high bed occupancy on Cobden unit. Staff from Cobden unit were able to offer advice and guidance to acute wards from where patients had been referred in order to assist in safe management of the patient until a bed became available There was no female psychiatric intensive care unit within the trust although Cobden unit carried out all assessments for female patients deemed to be in need of psychiatric intensive care. All female patients assessed as requiring psychiatric intensive care, accessed a private bed in the local area or were transferred out of area.

From 1 December 2015 to 31 May 2016 there were 16 delayed discharges across all wards. The ward with the highest number of delayed discharges was Moorside ward with eight followed by Hollingworth ward with five. The main reason for delayed discharges was waiting for placements to become available and other accommodation issues.

Discharges were planned to ensure they were at an appropriate time for the patients and their carers.

From 1 December 2015 to 31 May 2016 there had been 255 readmissions within 90 days for all acute and psychiatric intensive care wards. The ward with the highest

Are services responsive to people's needs?

Requires improvement

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

readmission rate was Moorside ward with 37 readmissions, followed by South ward with 35. The wards with the lowest readmission rate were Cobden unit with five readmissions followed by Hollingworth ward with 15 readmissions.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms and equipment to support treatment and care, although on some wards facilities had to be shared or rooms were used for a dual purpose. There were quiet areas on most wards although on Norbury ward we saw that there was a lack of quiet space for males.

There were phones on the ward to enable patients to make a phone call. On Norbury and Northside ward we saw that there was a patient phone but there was no hood and it did not provide any privacy to make a phone call. On North ward the phone was next to the nurses station and so provided limited privacy. However, patients had access to their mobile phones in their own rooms which meant they had privacy to make a phone call.

Access to outside space varied across all the wards. On Arden ward, patients had to use the balcony if they wanted a cigarette and to go outside they had to leave the ward and go downstairs. On Northside ward, there was no direct access to outside space. If patients wanted to go outside they had to go onto Southside ward and down a set of stairs. There was a therapeutic garden attached to Norbury ward. On North ward we saw there were facilities for physical activity including an outdoor gym and undercover pitch. On North ward there was also a vegetable growing garden that patients were using as part of an activity provided on the ward.

Most of the patients we spoke to gave negative reports about the quality of food on the wards. Some patients said that food was 'ok' but others said the food was 'not very good' or 'rubbish' and didn't look appetising. Some patients said that there could be more variety and they would have preferred the menu choices that were available in the main hospital. They said that snacks were not always available, although there were sometimes fruit available. There was access to hot drinks at all times. We were informed by the trust that the Patient Led Assessment of the Care Environment scores for food for 2016 had not yet been formally ratified which meant that they were not available at the time of our inspection.

There was access to activities Monday to Friday on all of the wards. We saw activity timetables for wards and saw that sessions included reiki, arts and crafts, cooking, music, yoga, outdoor sports and gardening. There was a snoezelen on Southside and Moorside wards which provided a relaxing environment with ambient lighting, bean bags and yoga mats. However, activities at weekends were limited. Patients said that there were not enough activities at the weekend although during the week they were good. We observed an occupational therapy group on Southside and Northside ward. Staff encouraged patients to be involved with the group, patients were attentive and participated in the activities which involved learning about their physical wellbeing.

Meeting the needs of all people who use the service

On all wards apart from Taylor ward there were accessible bedrooms and bathrooms for those with mobility difficulties. These bedrooms had adjustable bed frames. Bathrooms had baths and toilets with rails to assist patients.

Information leaflets were available to people in a range of different languages. These were available on the trust intranet and could be printed off when they were needed. Interpreters were accessed on a regular basis and whilst on inspection we spoke to a patient who spoke a different language with support from an interpreter. The care records we looked at demonstrated that interpreters were requested when patients had reviews of their care and treatment to ensure their understanding and full involvement.

There was a choice of food on all wards although some patients told us this was not as varied as in the main hospital. Dietary requirements of different religious and ethnic groups could be met and we spoke to patients who were provided with vegetarian, halal and kosher food.

Each acute ward had a multi faith resource.This was a cabinet that was divided into the different faiths. Patients could request use of the items within the cabinet. We were told that patients were found a private space on the ward for prayer. The multi faith resources were kept locked away when not in use. On Cobden unit all religious materials were accessible from the chaplaincy service who arranged for them to be delivered to the unit on request.

Are services responsive to people's needs?

Requires improvement

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

Listening to and learning from concerns and complaints

In the 12 months up to 13 June 2016 there were 36 complaints across the service. Of those complaints, six were fully upheld and 11 were partially upheld. No complaints were referred to the ombudsman.

Patients told us that they knew how to complain. On all of the wards we visited we saw information on the complaints process. There were weekly patient community meetings on each ward where patients had the opportunity to raise any issues they had. The notes from these meetings and feedback given to patients was displayed on the ward.

Patients and carers could complain, make comments or give compliments in a variety of ways.

Friends and family test cards were available on wards and in reception areas and this information was returned to the patient feedback team who then sent them to an external healthcare company to be inputted. Any negative comments from the friends and family test were shared with the wards prior to being inputted. Individual reports from friends and family test were shared with each ward on a monthly basis and at the acute care forum, where managers and patients met to discuss issues that had arisen across the wards. Any local complaints and compliments were shared with staff at team meetings and individually if necessary.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust's vision was to deliver the best care to patients, people and families in our local communities by working effectively with partners, to help people to live well.The trust had ten Principles of Care which were:

- Safe and effective services
- Meaningful and individualised
- Engaging and valuing
- Constructive challenge
- Governance procedures enable
- Focused and specific
- Competent skilled workforce
- Clear and open communication
- Visible leadership
- Shared accountability

Of the staff we spoke to most were aware of some, although not all of the principles of care.

Staff knew who the senior managers were in the trust. Staff told us that service managers for the trust often came onto the wards. They commented that they were approachable and listened to any feedback given to them.

Good governance

There were wards where some training fell below 75% compliance, these were:

- North ward - basic life support 74%
- Hollingworth ward - immediate life support 25%
- Saxon suite - information governance level one 70%, basic life support 60%, immediate life support 56%
- Taylor ward - moving and handling level one 74%, fire safety level one 52% and basic life support 72%.

Trust policy stated that supervision should take place every four to six weeks. Compliance rates for supervision were poor across all of the wards we went to and it was acknowledged by ward managers that this was an area that needed to be looked at. Trust policy stated that appraisals should be completed annually and we found on the majority of wards appraisal compliance was above 75% apart from on Taylor ward which was 59%.

We found a number of issues that had not been identified or acted upon. These included rapid tranquilisation monitoring forms that were missing or incomplete, staff were taken away from spending time from patients due to high bed occupancy levels and administrative duties and three wards did not comply with same sex accommodation guidance.

We looked at rotas to confirm the staffing mix on wards was appropriate. We saw that additional staff were sourced via the bank or through an agency when patients' clinical needs required extra resources to ensure the safety on the ward.

Staff undertook clinical audits. Pharmacy staff ensured regular audit of all medication management arrangements and notified ward managers and senior nursing staff if there were issues that required addressing with individual staff members. Other audits that staff had been involved in were window audits, health and safety audits, first aid and infection control.

The trust used key performance indicators to measure ward outcomes. Ward data was compiled by the service manager in the locality. These included discharge summaries sent to GP's within 24 hours and discharge letters sent to GP's within ten days, physical health checks, serious untoward incident investigations and response to complaints. Ward managers told us that trust also had commissioning and quality innovation targets for alcohol and smoking.

All ward managers told us they had sufficient authority to do their job and had administrative support. They were able to adjust staffing levels if necessary. Ward managers told us that they could submit items onto the trust risk register but no items had recently been submitted.

The Cobden unit manager attended a monthly governance and quality meeting that included all services within the specialist services division, including rehabilitation and high support wards. Information reviewed at this meeting included incidents and improvements, clinical issues such as physical health, national initiatives, and complaints.

Are services well-led?

Requires improvement

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.

Leadership, morale and staff engagement

Staff reported that morale was generally good. Staff told us they felt supported by managers across the wards we visited. Staff spoke positively about their roles and their commitment to providing quality patient care. Most staff reported that they liked working at the trust and had good support from their colleagues. All staff were able describe the principles of Duty of Candour. Staff told us that senior managers were accessible, approachable and encouraged openness.

Staff sickness rates were above the national average of 5% on all wards except North ward, Moorside ward and Cobden unit.

There were no bullying or harassment cases ongoing at the time of our inspection. Staff told us that they knew how to use the whistleblowing process and there was a policy they could refer to if they needed any further guidance on this. All of the staff apart from one felt that they could raise individual concerns without fear of victimisation. The one staff member we spoke to who felt they could not knew about the whistleblowing policy but did not want to use this.

There were opportunities for leadership development and ward managers told us that they had been on leadership courses provided by the trust.

Staff felt able to give feedback on inpatient services in a variety of different ways. There was an acute care forum where staff from each division could go to raise any issues they had. Ward managers had a monthly trustwide ward manager forum which enabled them to raise any issues. In addition there were team meeting discussions where feedback could be given to ward managers.

Commitment to quality improvement and innovation

At the time of our inspection, none of the wards were accredited by Accreditation for Inpatient Mental Health Services.

The trust had undertaken the 'Restrain yourself' research which was due to end in June 2016. This was a two year research programme being completed in partnerships with local universities that aimed to implement an intervention used in the United States of America designed to eliminate restraint and seclusion in NHS settings.

The trust was implementing the 'Safewards' initiative. This came from the Department of Health guidance on Positive and Proactive care published in 2014. Its aims were to reduce conflict and containment within psychiatric settings, in particular the use of restraint.

Seven of the acute wards were taking part in research called 'Developing a tool to measure therapeutic engagement'. Its aims were the test out a specifically designed questionnaire to measure the nature and effectiveness of therapeutic engagement and the impact it has on the quality of patient experience.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Patients on all wards were not always being provided with person-centred care due to high bed occupancy, the delegation of the bed management role out of hours and associated administrative tasks. This meant that staff were not always meeting the individual needs of patients in a timely manner. Patients did not always have a bed to return to upon return from leave. This meant that the continuity of care was disrupted as patients were sometimes admitted to a bed in other parts of the trust or out of area. Care plans across the wards were not always personalised. This is a breach of regulation 9 (1) (a)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: Northside, Southside, and Hollingworth wards did not comply with the Department of Health guidelines on eliminating mixed sex accommodation. On Northside and Southside wards male and female patients had bedrooms next to each other. On Hollingworth ward the corridor where the female bathroom was situated was not female only, therefore any female using the bathroom would have to walk through an area where there were men.

This section is primarily information for the provider

Requirement notices

Patients from Northside ward had to go through Southside ward to have access to outside space. This meant that the safety, privacy and dignity of patients on both wards was compromised.

This is a breach of regulation 10 (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Rapid tranquilisation monitoring forms on North ward were missing for three out of five forms we looked at. One form was not completed as per trust policy. The fridge temperatures on Southside and South ward were not monitored properly. The clinic room was consistently above the recommended maximum temperature on Cobden unit. On Southside ward there was a gap in the recording of anticoagulant medication for six days which meant that the patient may have missed seven doses. Doctors did not always follow trust policy when cancelling medicines on a patient's chart on Southside ward. This is a breach of regulation 12 (2) (a)(b)(g)

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

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

How the regulation was not being met:

Supervision was not completed in line with trust policy across all wards. In some supervision files we could see no evidence of supervision taking place and in others supervision had not taken place for up to two years.

Mandatory training on some wards did not meet trust targets. These were North ward - basic life support 74%, Hollingworth ward - immediate life support 25%,Saxon suite - information governance level one 70%, basic life support 60%, immediate life support 56%,Taylor ward - moving and handling level one 74%,fire safety level one 52% and basic life support 72%.

This is a breach of regulation 18 (2) (a)