Manchester Mental Health and Social Care Trust

Perinatal services

Quality Report

Andersen Ward
Laureate House
Wythenshawe hospital
Southmoor Road
Manchester
M23 9LT
Tel:0161 291 6822
Website: mhsc.nhs.uk

Date of inspection visit: 26 March 2015
Date of publication: 05/10/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAE02	Laureate House	Andersen Ward	M23 9LT

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care 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 Manchester Mental Health and Social Care Trust and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care Trust.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The ward provided a safe clean and welcoming environment which was furnished to meet the needs of the mother and baby.

Risk assessments and management plans were available for patients and a ligature audit risk assessment had highlighted areas that were detailed on the risk register. Interventions had been implemented to ensure the safety of patients.

New staff to the ward received induction training specific to the patient group.

There was a weekly ward round attended by ward based staff, members of the external care team and patients to discuss on going care and discharge planning.

Patients were mainly positive about the support which they received on the unit.

Clear assessments were in place to ensure that the wards admission criteria was being adhered to.

The unit has been accredited through the Royal College of Psychiatrists Quality network for Perinatal Mental Health Services accreditation scheme. This was due for renewal in July 2015.

The staff had a good understanding of the complaints process and there were methods in place to ensure that lessons from incidents are shared.

Recent staff shortages have impacted on staff morale due to high workloads and support required to assist bank and agency workers. New staff were due to join the service in April and staff reported that morale was now lifting.

But we also found

There was no protocol in place to support fathers remaining on the unit through the night. We raised this issue with the trust during our inspection and we received assurances that this practice would be halted until a protocol was in place and the trust could be assured that patients and their babies were not placed at risk by visitors staying overnight.

Mandatory training in all areas was below the trust standard of 90%. Regular clinical and managerial supervision was not in place to support nursing staff.

Fridge temperatures were not checked and recorded on a daily basis.

There was no provision for levels of observation to be reviewed and reduced as appropriate over the weekend.

Mobile alarms often went missing as there was no robust system in place to ensure they were logged out and returned each shift.

Medication cards were not always completed correctly. Whilst this had low level impact on patient care due to the nature of the medication omitted, the process for administration, recording and monitoring showed room for improvement.

We currently only rate core services and as perinatal services do not fall within our definition of core services, we have not rated the service.

Summary of findings

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

Are services safe?

We found:

- Patients told us that they felt safe on the ward.
- Staff were responsive if individual concerns were identified.
- Staff knew how to safeguard people who used the service from harm.
- Incidents/accidents were reported and there was a system in place for reviewing and learning from them.
- Risk assessments and care plans were completed for mother and baby.
- Ligature risks were identified and listed on the risk register with practice in place to ensure risks are mitigated.
- Systems were in place to ensure adequate staffing levels. Having an experienced and appropriate skill mix on the unit has been impacted through recent staffing difficulties.

However:

- The clinical room did not have an examination couch..
- There was no protocol in place to support fathers remaining on the unit over night. We raised this issue with the trust during our inspection and we received assurances that this practice would be halted until a protocol was in place and the trust could be assured that patients and their babies were not placed at risk by visitors staying overnight.
- Fridge temperatures were not checked and recorded on a daily basis.
- There was no provision for levels of observation to be reviewed and reduced as appropriate over the weekend.
- Mobile alarms often went missing as there was no robust system in place to ensure they were logged out and returned each shift.
- Medication cards were not always completed correctly. Whilst this had low level impact on patient care due to the nature of the medication omitted, the process for administration, recording and monitoring showed room for improvement.

Are services effective?

We found :

- Assessments and updated care plans were in place. Staff had identified physical healthcare needs and care plans were in place to support these.
- Different professions work with the nursing team to plan care and treatment. programmes for patients.

Summary of findings

However:

- Mandatory training in all areas was below the trust standard of 90%. We were advised this was due to staff sickness and sudden unexpected staff turnover.
- Regular clinical and managerial supervision was not in place to support nursing staff.
- The ward had a Mental Health Act 1983 Monitoring Visit on 11 March 2015 so this was not covered in this inspection. Issues raised included consent to treatment, availability of the IMHA service, authorisation of section 17 leave and patient participation in care planning. . At the time of the inspection, we were awaiting the trust to submit a provider action statement to inform us how they were going to make improvements.

Are services caring?

We found:

- Patients were mostly positive about the support which they received on the unit.
- Staff explained to us how they deliver care to individual patients. This demonstrated that they had a good understanding of the needs of patients on the unit.
- Advocates were available on the unit and there was information available in the ward about access to advocacy services.

Are services responsive to people's needs?

We found:

- Clear assessments were in place to ensure that the admission criteria was being met.
- NHS England reported good responsive joint working with the ward.
- Discharge was well planned in collaboration with the patient and external providers.
- Patients had access to a garden area and rooms were provided to allow for visiting on the ward.
- The accommodation had designated areas to provide for the care and welfare of infants.
- Staff understood the complaints procedure and patients knew how to raise a complaint.
- Feedback on investigations and complaints was through staff meetings.

Are services well-led?

We found:

Summary of findings

- Staff were aware of the trust's vision and values.
- The ward manager informed us that she operated an open door policy and staff told us that they found her approachable and supportive.
- Staff reported morale had been low due to staffing difficulties but vacant positions have been recruited into. Staff sickness levels had reduced and morale was improving.
- The ward had a risk register which was reviewed and updated on a regular basis.
- The ward had been accredited through the Royal College of Psychiatrists Quality network for Perinatal Mental Health Services accreditation scheme.
- Commissioners reported that communication with the ward was open and transparent.

However

- Mandatory training was not completed to the standard set by the trust.
- Staff received annual appraisals but there was no structure for the provision of managerial or clinical supervision.

Summary of findings

Background to the service

Andersen Ward is a 10 bed Mother and Baby Unit which covers the North West of England. It is located on the ground floor of Laureate House at Wythenshawe Hospital, Manchester.

Perinatal mental health services are concerned with the prevention, detection and management of perinatal mental health problems that complicate pregnancy and the postpartum year. These problems include both new onset problems, recurrences of previous problems in women who have been well for sometime, and those with mental health problems before they became pregnant.

Our inspection team

Our inspection team was led by:

Chair: Steve Shrubb, Chief Executive Officer, West London Mental Health NHS Trust

Team Leader: Brian Burke, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team that inspected the perinatal service consisted of one CQC inspector, one perinatal nurse and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of the experience of people who use services', we always ask the following five questions of every service and provider:

· Is it safe?

· Is it effective?

· Is it caring?

· Is it responsive to people's needs?

· Is it well-led?

We carried out an announced visit to Andersen Ward on 26 March 2015.

During the visit we met and interviewed the ward manager and two nurses who worked within the service.

We met with three patients who were using the services who shared their views and experiences of the ward.

We reviewed record of three patients.

We observed how patients were being cared for, made a tour of the ward, attended handover and reviewed a range of policies, procedures and clinical and managerial records relating to the running of the ward.

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What people who use the provider's services say

Patients reported that they felt safe on the ward and they received good care.

Patients made comment that nursing staff spent a lot of time in the office and one patient felt intimidated to knock on the door.

Summary of findings

Good practice

The ward had a self contained flat that could be utilised to support a graded discharge if appropriate.

The ward maintained contact with patients seven days post discharge to ensure continuity of care into the community.

The unit had been accredited through the Royal College of Psychiatrists Quality network for Perinatal Mental Health Services accreditation scheme. This was due for renewal in July 2015.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should ensure that there is a comprehensive visiting policy in place with thorough risk assessments where special considerations are required. In particular relating to fathers remaining on the ward through the night.

The trust should ensure that fridge temperatures on the ward are checked daily and temperatures recorded.

The trust should ensure there is a robust system for monitoring the availability of mobile alarms for staff use.

The trust should ensure there is provision to review the reduction of levels of observations every day including the weekend period.

The ward should ensure that care plans are individualised to meet the needs of patients.

Patients should always be offered a copy of their care plan and this should be clearly recorded.

Mandatory training should be undertaken to the standard set by the trust.

Clinical and managerial supervision should be undertaken, structured and recorded in accordance with the trust policy

The ward should consider how the administration of medication is improved, monitored & audited for accuracy.

The ward should consider an appropriate space for clinical examinations of mothers' and their babies other than the mothers rooms by providing an examination couch in the clinical room.

Manchester Mental Health and Social Care Trust

Perinatal services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Andersen Ward	Laureate House

Mental Health Act responsibilities

The ward had a Mental Health Act 1983 Monitoring Visit on 11 March 2015. So this was not covered in this inspection. Issues raised included consent to treatment, availability of the IMHA service, authorisation of section 17 leave and patient participation in care planning. At the time of the inspection, we were awaiting the trust to submit a provider action statement to inform us how they were going to make improvements.

We did not find evidence that the Responsible Clinician was carrying out and recording an assessment of patients' consent to treatment at the first admission of treatment for mental disorder.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff records showed only 30% of staff had received up to date training on the Mental Capacity Act. This was due to high volumes of staff sickness and sudden staff turnover. However the staff we spoke to had a good understanding of the MCA.

Are services safe?

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

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

Summary of findings

We found:

- Patients told us that they felt safe on the ward.
- Staff were responsive if individual concerns were identified.
- Staff knew how to safeguard people who used the service from harm.
- Incidents/accidents were reported and there was a system in place for reviewing and learning from them.
- Risk assessments and care plans were completed for mother and baby.
- Ligature risks were identified and listed on the risk register with practice in place to ensure risks are mitigated.
- Systems were in place to ensure adequate staffing levels. Having an experienced and appropriate skill mix on the unit has been impacted through recent staffing difficulties.

However:

- The clinical room did not have an examination couch..
- There was no protocol in place to support fathers remaining on the unit over night. We raised this issue with the trust during our inspection and we received assurances that this practice would be halted until a protocol was in place and the trust could be assured that patients and their babies were not placed at risk by visitors staying overnight.
- Fridge temperatures were not checked and recorded on a daily basis.
- There was no provision for levels of observation to be reviewed and reduced as appropriate over the weekend.
- Mobile alarms often went missing as there was no robust system in place to ensure they were logged out and returned each shift.
- Medication cards were not always completed correctly. Whilst this had low level impact on patient care due to the nature of the medication omitted, the process for administration, recording and monitoring showed room for improvement.

Our findings

Safe and clean ward environment

- The ward was clean and bright with lots of baby orientated displays and toys available for interaction with mother & baby.
- Fridges were not being checked daily. The dining room fridge showed 4 daily checks in February and none listed for March.
- There were some ligature risks on the ward and these had been noted on the risk register. Interventions were in place to support the mitigation of risk.
- The ward layout enabled line of sight from a central communal point.
- Patients told us they felt safe here.
- The clinical room was clean & well organised. Drugs were stored & checked correctly.
- The clinical room did not have an examination couch, we were advised that most physical examinations were undertaken off the ward.
- Staff have access to mobile alarm units which were carried at all times. Staff reported that alarms often went missing & there was no robust method of recording alarms in and out.
- There was no seclusion room.

Safe staffing

- We reviewed the current and previous staff rotas and these showed us that there were enough staff on duty to meet the needs of the patients on this unit.
- The ward currently had six nursing (two qualified and one unqualified) vacancies, five await start dates in April. The staffing levels were maintained using overtime, regular bank and agency staff .

Are services safe?

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

- Each person had a named worker and associate worker. The goal was for patients to have a session with their named worker at least once a week and this was being achieved.
- Whilst the ward was locked for the security of the infants, there were clear notices advising how patients could leave the ward & all patients were aware of this.
- During the day there was a consultant psychiatrist available most week days and there were on call arrangements out of hours across the hospital.
- New staff received an induction to the unit.

Assessing and managing risks to patients and staff

- Risk assessments were comprehensive and identified where additional support was required taking into account the patient group.
- Varying levels of observation were in place according to individual risk assessment. Nursing staff were empowered to make increases to observations however we were informed that only consultant psychiatrists were able to reduce levels of observation. The trust policy states that levels of observation should be reviewed daily and adjusted according to the risk status of the patient. We were informed that reductions to observation levels do not happen over the weekend period
- We saw a detailed risk management plan to support the use of restraint for a patient should this be necessary. There was the facility to transfer patients to acute services if risks increased & were not able to be managed on the ward.
- Staff had a good understanding of safeguarding procedures. We noted that 83% of staff had attended safeguarding training.
- We viewed six medication charts & all cards had days when medication had been omitted with no reason logged. This was medication or creams relating to minor physical health conditions. We were advised this is often due to patients not being present on the unit, either on home leave or off the unit. Whilst this had low level impact on patient care due to the nature of the medication omitted, the process for administration, recording and monitoring showed room for improvement
- Visiting was encouraged to support family life and recovery, however we were made aware that on occasion due to the large catchment area of the patient group, fathers are on occasion allowed to stay over on the ward. There was no formal risk tool or protocol in place to support this process. We raised this issue with the trust during our inspection and we received assurances that this practice would be halted until a protocol was in place and the trust could be assured that patients and their babies were not placed at risk by visitors staying overnight.

Reporting incidents and learning from when things go

- Incidents were reported through the Trust computerised system and also reported into NHS England. Staff showed a good understanding of how to report incidents.
- Staff meetings were not taking place on a regular basis prior to March. However from March 2015 meetings had a structured agenda & were place every two weeks. This was the main venue for sharing learning from incidents. Staff who were unable to attend received this information via email.
- The ward manager demonstrated how she attended monthly ward manager meetings where incidents were discussed.

Are services effective?

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

Summary of findings

We found :

- Assessments and updated care plans were in place. Staff had identified physical healthcare needs and care plans were in place to support these.
- Different professions work with the nursing team to plan care and treatment. programmes for patients.

However:

- Mandatory training in all areas was below the trust standard of 90%. We were advised this was due to staff sickness and sudden unexpected staff turnover.
- Regular clinical and managerial supervision was not in place to support nursing staff.
- The ward had a Mental Health Act 1983 Monitoring Visit on 11 March 2015 so this was not covered in this inspection. Issues raised included consent to treatment, availability of the IMHA service, authorisation of section 17 leave and patient participation in care planning. . At the time of the inspection, we were awaiting the trust to submit a provider action statement to inform us how they were going to make improvements.

Our findings

Assessment of needs and planning of care

- Detailed assessments werecompleted prior to admission to ensure the ward could meet the needs of the patient. Physical examinations of mother & baby were completed on admission.
- An electronic patient record system was in operation for the mothers on the unit. Baby care plans were written records.
- Care records were very structured and nurse led with some aspects being standardised at hospital level. There was little evidence that patients were involved in compiling some of the care plans. Some of the standard structure & detail was not applicable to each patient but this was not amended to accommodate individual needs. Patients told us they did feel involved in their care and they did see and sign them but they did not receive copies.

Best practice in treatment and care

- The unit had been accredited through the Royal College of Psychiatrists accreditation scheme, this is due for renewal in July 2015.
- NHS England, who commission the service, advised that the ward met their requirements which were assessed through quarterly reporting mechanisms.
- The ward had access to a psychologist two days per week.
- Medication was administered by a trained nurse from the clinical room. There was a lead nurse for medication on the unit.

Skilled staff to deliver care

- The unit was very nurse led with routine decisions on admission being taken by the nursing staff.
- A psychologist was available two days a week for one to one work or consultation.
- The ward had secured funding for a full time occupational therapist following a temporary appointment which was successful. This position was about to be advertised.
- The ward has recently lost five registered mental nurses who had left for a variety of reasons. Recruitment to fill these posts was almost complete.
- Mandatory training compliance was below the trust standard of 90%:Information Governance 60%, Safeguarding 83%, Medicine Management 85%, Mental Capacity Act 30%, Mental Health Act 50%, Infection Control 85%. We were advised that was due to staff sickness and sudden staff turnover. There was a plan in place to ensure mandatory training would be brought up to date for all staff.
- There was no formal management supervision taking place & clinical supervision was only undertaken on an ad-hoc basis.
- A new appraisal was being rolled out and the ward was on track with this.
- Team meetings were sporadic but there was now a structure in place with a detailed agenda.
- There was an induction pack specific to the ward to support new staff.

Multi-disciplinary and inter-agency team work

- A ward round was undertaken weekly and every patient had a 45 minute meeting scheduled.

Are services effective?

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.

- Outside agencies were invited to ward rounds and care programme approach meetings. NHS England advise that the service had good connections with safeguarding bodies both child & adult & the ward had successfully managed complex cases.
- Handover took place in a separate room to avoid interruption and a standard template was seen in use which provided high levels of detail to be handed to the next shift.

Adherence to the MHA and MHA code of practice

A full Mental Health Act 1983 Monitoring Visit was undertaken on 11 March 2015 therefore this was not covered on this inspection, A list of the actions to be addressed is listed in the summery for this section. Only 50% of staff had received their refresher training for Mental Health Act 2014/2015 due to high levels of sickness and sudden staff turnover. However, the staff we spoke to had a good knowledge of the Mental Health Act.

Good practice in applying the MCA

Only 30% of staff had received their refresher training for 2014/2015 due to high levels of sickness and sudden staff turnover. However, the staff we spoke to had a good knowledge of the Mental Capacity Act.

Are services caring?

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

Summary of findings

We found :

- Patients were mostly positive about the support which they received on the unit.
- Staff explained to us how they deliver care to individual patients. This demonstrated that they had a good understanding of the needs of patients on the unit.
- Advocates were available on the unit and there was information available in the ward about access to advocacy services.

Our findings

Kindness, dignity, respect and support

- Patients told us that the staff were helpful, kind and knowledgeable. Support was offered both to themselves and also in caring for their baby.
- Patients reported there were enough staff on the ward but staff spent a lot of time in the office and one patient reported feeling intimidated to knock on the office door
- Staff demonstrated that they had a good understanding of the needs of patients on this ward.

The involvement of people in the care they receive

- There was a comprehensive admission checklist which was completed.
- Patients received a welcome pack when admitted.
- Patients felt involved in their care & attended a weekly ward round to discuss their needs. Members of their home team were always invited to attend ward round and patients told us they found this very beneficial.
- There was a notice clearly displayed on the ward with how to access advocacy. One patient had just had an advocate assigned to support them.
- Community meetings were held twice weekly and patients were encouraged to attend and contribute.
- Patients on the unit were not currently involved in the recruitments of staff.

Are services responsive to people's needs?

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

Summary of findings

We found :

- Clear assessments were in place to ensure that the admission criteria was being met.
- NHS England reported good responsive joint working with the ward.
- Discharge was well planned in collaboration with the patient and external providers.
- Patients had access to a garden area and rooms were provided to allow for visiting on the ward.
- The accommodation had designated areas to provide for the care and welfare of infants.
- Staff understood the complaints procedure and patients knew how to raise a complaint.
- Feedback on investigations and complaints was through staff meetings.

Our findings

Access discharge and bed management

- Referrals were received from a large catchment area covering the North West of England. Nurses were able to assess referrals based on a strict admission criteria and make judgements about admission. The unit responded quickly and had often admitted patients the same day or within a few days if beds were available. NHS England reported that the service was very responsive to referrals.
- Should there be an increase in a patient's risk, the ward could arrange for transfer to the PICU or acute services within the hospital- subject to availability of beds. This had happened on occasion. Wherever possible when risks decreased, patients were transferred back to the ward. Arrangements for baby were discussed at this time and the baby might remain on the ward temporarily or may go home to be with family depending on circumstances.
- Discharge was planned and external services were involved in the transition through weekly ward rounds and reviews.
- The ward maintained contact with patients for seven days post discharge to ensure the community mental health team had made contact.
- There was a self-contained flat available on the unit to support independent living prior to discharge if required.

The ward optimises recovery, comfort and dignity

- Patients' rooms were designed to accommodate mother and baby. Rooms were divided into pairs with bathroom facilities shared between two patients.
- There was access to a garden area which was well kept and provided sheltered seating & tables.
- Patients had access to private rooms for visiting.
- A phone was available for patients use with privacy. Mobile phones could be used on the ward.
- There was no computer or internet service provided.
- Patients reported that the food was of good quality but meal times were set and there were restrictions around preparing meals due to risk issues.
- Hot and cold drinks were available 24/7.
- There was a timetable of limited activities. However this was discussed in the community meeting and could be varied depending on patients' views. All patients felt they would benefit from more psychological input either individual or group.
- The staff welcomed the appointment of a new occupational therapist to improve the provision of meaningful activity, this was currently being advertised.

Meeting the needs of all people who use the service

- The ward had facilities for accommodating people with physical disabilities.
- The ward had facilities for the care and welfare of infants on the ward.
- A full range of booklets were on display with information on patients' rights, how to complain, how to access advocacy and information about local services.
- We saw evidence that interpreters were made available on the ward to support the range of languages used by patients.
- Patients were offered spiritual support by arranging visits to the ward or patients could be supported to attend outside religious/spiritual services.

Are services responsive to people's needs?

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

Listening and learning from concerns and complaints

- . Patients told us that concerns were easily addressed through regular community meetings and staff availability ensuring any concerns were dealt with and resolved at the time.
- Staff had a good understanding of the complaint process.

Are services well-led?

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

Summary of findings

We found :

- Staff were aware of the trust's vision and values.
- The ward manager informed us that she operated an open door policy and staff told us that they found her approachable and supportive.
- Staff reported morale had been low due to staffing difficulties but vacant positions have been recruited into. Staff sickness levels had reduced and morale was improving.
- The ward had a risk register which was reviewed and updated on a regular basis.
- The ward had been accredited through the Royal College of Psychiatrists Quality network for Perinatal Mental Health Services accreditation scheme.
- Commissioners reported that communication with the ward was open and transparent.

However

- Mandatory training was not completed to the 90% standard set by the trust. We were informed that some of this was due to the extra workload undertaken by regular staff during the current staffing difficulties. We saw out of date training had been planned over the coming months.
- Staff received annual appraisals but there was no structure for the provision of managerial or clinical supervision.

Our findings

Vision and values

- Staff had an overview of the organisational values and an understanding of how the objectives related to Andersen ward.
- Staff knew who some of the board members were and reported that occasionally they received a visit.

Good governance

- Mandatory training compliance was below the trust standard of 90%:Information Governance 60%, Safeguarding 83%, Medicine Management 85%, Mental Capacity Act 30%, Mental Health Act 50%, Infection Control 85%.We were informed that some of this was due to the extra workload undertaken by regular staff during the current staffing difficulties. We saw out of date training had been planned over the coming months.
- There was no system in place to deliver formal documented management or clinical supervision in accordance with trust policy..
- Recent staff vacancies had been covered in the main by regular bank and agency staff.
- Staff meetings prior to March 2015 were sporadic and lacked regular focus. However a new system of regular two weekly meetings had recently been developed with a comprehensive agenda covering a wide range of issues. For those staff not in attendance, the minutes were to be displayed in the nurse's office and emailed individually to each staff member.
- The ward reports in to NHS England under key performance indicators and CQUIN measurements. Feedback from commissioners was favourable stating the ward had met Commissioning for Quality and Innovation goals (CQUINs), the documentation was good, the ward was a responsive service, open and transparent, case management worked well, there was good communication and evidence of outcomes, good links to Safeguarding for children and adults and some complex care cases were managed well.
- The ward manager reported that she felt empowered to make requests for change which were listened to by the board. An example of this was the recruitment of a new occupational therapist to the service.
- The ward had a risk register which was reviewed and updated.

Leadership morale and staff engagement

- Sickness had been as high as 18% at times in the last six months. Two Staff members on long term sick leave had now returned to work and the situation was much improved. Together with six staff vacancies this had put extra pressure on regular staff members who had worked overtime and needed to support bank and agency staff.
- Staff told us how staffing difficulties had impacted on staff morale which had been low. However staff were hopeful that new staff and the introduction of a permanent occupational therapist would add great strength to the team and staff morale had improved.

Are services well-led?

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

- Staff reported the manager as approachable and supportive. They would be comfortable raising concerns with her.

Commitment to quality improvement and innovation

- The ward had been accredited through the Royal College of Psychiatrist Quality network for Perinatal Mental Health Services accreditation scheme. This is due for renewal in July 2015.
- The ward manager advised us that the psychologist was undertaking a research project 'Triple P' with regard to mother and baby interactions on the ward. Ward based staff were supporting with the research.