Requires improvement

Lincolnshire Partnership 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)
RP7EV	Mental Health Unit, Lincoln County Hospital Site	Peter Hodgkinson Centre Conolly and Charlesworth Wards	LN2 5QY
RP7LA	Mental Health Unit, Pilgrim Hospital	Ward 12	PE21 9QS
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This report describes our judgement of the quality of care provided within this core service by Lincolnshire Partnership 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.

Summary of findings

Where applicable, we have reported on each core service provided by Lincolnshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Lincolnshire Partnership 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?	**Inadequate** 
Are services effective?	**Good** 
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

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Summary of findings

Overall summary

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

- There were features of the ward environment that were unsafe.We identified potential ligature anchor points that had not been included in the trust's ligature risk audits. The trust had identified other ligature risks but in some areas had no plans in place to manage patient safety. The seclusion room on Ward 12 contained ligature points in the toilet facilities. Staff could not observe patients in this area and entered the room to ensure patient safety. This was a risk to both patients and staff. There were further ligature points in patient bedroom areas and anti-ligature wardrobes had not been secured to walls. There were also ligature points in the courtyards. The floor of one courtyard was uneven.There was no nurse call system for patients to summon assistance if needed.We reported our findings to the trust.At the time of the follow-up inspection, the trust was making plans to take action to rectify these issues.
- Most beds were situated in bays. Some patients told us they did not feel safe and these areas lacked privacy.
- Bed occupancy rates were often over 100%. This meant that staff needed to use leave beds for new admissions.
- We found different protocols and working practices in operation across the acute wards. This also meant that some informal and detained patients had restricted access to fresh air at night.
- Some Mental Health Act (MHA) paperwork used to record patient's rights was out of date and MHA patient leave forms lacked clarity.
- Compliance with mandatory training was below the trust's own target. Compliance with Mental Capacity Act and MHA training was particularly low with 35% and 66% of staff having been trained respectively. The trust could not be sure that staff had received appropriate training for their role.
- Staff did not always receive supervision in a timely manner. The trust could not be sure that professional and developmental issues were discussed with staff.
- The trust had no psychiatric intensive care (PICU) beds. Staff told us there were often delays in transferring patients to suitable PICU beds. The trust had plans to provide PICU facilities in the near future.
- Patients told us the food was of good quality however, there was no hot meal in the evening. Patients told us they disliked having sandwiches every evening. This did not meet the recommendations of the Hospital Food Standards Panel.

However:

- Wards were clean and had ample rooms for activities and patient visits. The trust provided activities on all wards, including at weekends.
- Patients had individualised risk assessments, with plans in place to manage risks. Care plans were comprehensive and holistic, and addressed a full range of needs and problems.
- Patients received regular monitoring of their physical healthcare needs.
- Clinical nurse leads undertook relevant audits and there was good evidence of effective multi-disciplinary team working. There were good medicines management processes and clinic rooms were clean and tidy. Good systems were in place for reporting and recording incidents and complaints.
- Staff were professional and respectful. Most patients told us staff were caring. Staff showed a good understanding of the care and treatment needs of patients and we observed good interactions between patients and staff.
- All three wards had achieved accreditation under the Royal College of Psychiatrists AIMS standards.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- There were ligature points across all three wards that were not always included in the trust ligature risk audits. The trust had identified other ligature points, but had no management plans in place to ensure patient safety.
- One courtyard area was small and unpleasant and had an uneven floor surface. Courtyards did not have means to summon nurse assistance in an emergency and when staff were not present. This was a risk to patients. The trust responded to our findings and submitted plans to make required changes.
- The seclusion room on Ward 12 contained ligature points in the toilet facilities. Staff could not observe patients in this area and entered the room to ensure patient safety. This was a risk to both patients and staff.
- Most beds were situated in bays. Some patients told us they did not feel safe and these areas lacked privacy.
- The seclusion rooms on Conolly and Charlesworth wards were opposite the bed bays. This affected the privacy and dignity of patients. On Conolly ward there was no privacy blind in place.
- We found different protocols and working practices in operation across the acute wards. This also meant that some informal and detained patients had restricted access to fresh air at night.
- Lessons learnt had not been shared across the site. For example, changes to ward protocols made on one ward, following a serious incident, were not replicated on another.
- Mandatory training compliance was below the trust's target, for example, compliance with restrictive intervention (restraint) training was 75% and Mental Capacity Act was 35%.

However:

- Wards were clean and tidy with adequate rooms for care and treatment.
- The wards had a range of staff to deliver care and treatment to patients.
- A 'safe care' system promoted accurate staffing levels and sent all staffing requests to a central team. This promoted continuity of care and reduced nursing time in booking staff.
- Patients had individualised risk assessments with plans in place to manage risks.

Summary of findings

- There were good processes for the storage, recording and dispensing of medication. Clinic rooms were clean and tidy. Emergency drugs were available and controlled drugs were appropriately stored and recorded in the register.
- There were good systems for reporting, recording and reviewing incidents.

Are services effective?

Good

We rated effective as **good** because:

- Care plans were comprehensive and holistic, and contained a full range of needs and problems.
- Patients received regular monitoring of physical healthcare needs.
- Nursing staff were actively involved in clinical audit across.
- Multi-disciplinary team working was effective.

However:

- Staff did not always receive supervision in a timely manner. The trust could not be sure that professional and developmental issues were identified.
- The wards did not have a psychologist.
- There were some discrepancies with MHA paperwork, for example, section 17 leave forms lacked information related to terms and conditions of leave and some paperwork used to record patient's rights was out of date.

Are services caring?

Good

We rated caring as **good** because:

- We observed staff interactions with patients. Staff were responsive to patient needs, discreet and respectful.
- On Charlesworth ward, staff were looking after a patient suffering from terminal illness. The delivery of care was compassionate and dignified.
- We observed good relationships between patients and staff on all wards. Staff were passionate and enthusiastic about providing care to patients with complex needs. They demonstrated good understanding of the care and treatment needs of patients.
- There were dedicated areas for patients to see their visitors.
- Appropriate arrangements were in place for children visiting.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

Summary of findings

- Bed occupancy rates were over 100%. This meant that the trust used leave beds for new admissions.
- The trust had no psychiatric intensive care (PICU) beds. Staff told us there were often delays in transferring patients to suitable PICU beds.
- At the time of the inspection, there were 27 patients placed in out of area acute beds (that is, beds that were not within the trust's catchment area) due to a lack of appropriate beds.
- There was no hot meal in the evening. Patients told us they disliked having sandwiches every evening.

However:

- All wards had access to quiet areas and activity rooms.
- There was a varied activities programme on all wards.
- The trust had a system for recording and monitoring complaints.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** because:

- Governance processes for management of ligature risks was not robust. We reported our findings to the trust. At the time of the follow-up inspection, the trust was making plans to take action to rectify these issues.
- Following a serious incident, the trust had developed a protocol to address the identified risk however, this had not been implemented across all wards. Different paperwork was in use between wards and some Mental Health Act forms had not been updated following changes to the MHA.
- There were differing practices between wards, for example, two wards had different protocols for access to outside space at night, and between voluntary and detained patients.

However:

- Staff told us that they felt part of a team and received support from each other.
- Ward managers were highly visible on the wards, approachable and supportive. We were impressed with the morale of the staff we spoke with and found that the local teams were cohesive and enthusiastic.

Summary of findings

- All three wards have achieved accreditation under the Royal College of Psychiatrists (RCPsych) AIMS standards. The acute care clinical specialist occupational therapist was also a member of the RCPsych AIMS Accreditation Committee and RCPsych AIMS Adult Acute In-Patient Advisory Group.

Summary of findings

Information about the service

The acute wards for adults of working age provided by Lincolnshire Partnership NHS Foundation Trust are part of the trust's acute division. The wards are situated over two sites.

Lincoln Hospital, The Peter Hodgkinson Centre, has two wards for adults of working age: Charlesworth and Conolly. Charlesworth has 20 beds and is for females only. Conolly has 22 beds and is for males only.

Pilgrim Hospital in Boston has one ward. Ward 12 has 20 beds and admits both males and females. There are also beds specifically for patients referred by the Ministry of Defence.

All wards accept patients detained under the Mental Health Act. The trust does not have a psychiatric intensive care facility.

Since 2011, the Care Quality Commission has conducted 30 inspections across 9 sites. The latest inspection judgements found all sites compliant.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive of Oxford health NHS foundation trust.

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Lyn Critchley, Inspection Manager, mental health hospitals, CQC

The team that inspected the acute wards for adults of working age and psychiatric intensive care units consisted of seven people: one inspector, two specialist advisors (one nurse and one consultant psychiatrist), two Mental Health Act reviewers, one pharmacist and one expert by experience that had personal experience of using, or caring for someone who uses, the type of services we inspected.

The team would like to thank all those who met and spoke to the team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

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 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 using the service.

During the inspection visit, the inspection team:

- Visited all wards, reviewed the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 21 patients who were using the service.
- Spoke with one carer.
- Reviewed 21 care and treatment records of patients.
- Reviewed 55 medication charts across the sites.
- Interviewed three ward managers.
- Spoke with 25 staff individually, including consultant psychiatrists, nurse consultant, nurses, support workers and activity co-ordinators.
- Spoke with other professionals, including a pharmacist, a pharmacy technician, occupational therapist, housekeeper and administration staff.
- Attended three shift handovers, one group therapy session and one care review meeting.
- Carried out a specific check of the medication management on all wards.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Completed an unannounced inspection of Ward 12 at Pilgrim Hospital on 16 December 2015.

What people who use the provider's services say

The majority of patients were positive about their care and treatment and felt that staff were compassionate and caring. Most patients were involved in their care plans. However, some patients did not agree with them. Families and carers had the opportunity to be involved in care reviews. Most patients told us there were activities during the day. Some patients told us they were not aware of their rights or how to complain.

Most patients we spoke with felt safe on the wards. However, some patients did not like being accommodated in bays and would prefer single rooms.

Most patients told us the food was good; however, they would prefer the offer of a hot meal in the evening.

Good practice

We observed excellent care provided to a terminally ill patient on Charlesworth Ward. The circumstances were unusual for this environment but staff were dedicated, compassionate and caring. Appropriate capacity assessments were in place to ensure the patient's rights were protected and specialist staff were employed to meet care needs.

We felt staff were to be commended for the dignified and compassionate care they provided for this patient, under unusual and difficult circumstances.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all ligature risks are identified on the ligature risk audit.
- The trust must ensure that they do all that is reasonably practicable to mitigate any such risks.
- The trust must ensure that clinical staff receive regular supervision.
- The trust must ensure that staff receive mandatory training in line with trust targets.
- The trust must ensure that patients' dietary preferences are considered at mealtimes.
- The trust must ensure that changes made because of lessons learnt are implemented in all areas.

Lincolnshire Partnership 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
Peter Hodgkinson Centre, Conolly Ward	Mental Health Unit, Lincoln County Hospital Site
Peter Hodgkinson Centre, Charlesworth Ward	Mental Health Unit, Lincoln County Hospital Site
Ward 12	Mental Health Unit, Pilgrim 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.

Mental Health Act (MHA) detention paperwork had been completed correctly. There was administrative support to ensure detention paperwork was up to date and regular audits took place. There was a clear process for scrutinising and checking the receipt of MHA paperwork.

Overall, the MHA record keeping and scrutiny was satisfactory. We were concerned, however, that the trust stored original detention papers on the wards as this might pose a risk of papers being lost or damaged. MHA paperwork was scanned onto the electronic record for staff reference.

Systems were in place to ensure compliance with the MHA. Adherence to the guiding principles of the MHA Code of Practice was good. However, some paperwork used to record patients' rights on Conolly ward was out of date and several records did not indicate whether patients were aware of their rights to access independent mental health advocacy.

Wards displayed posters informing patients of how to contact the independent mental health advocate.

Sixty six per cent of staff members working within this core service had received training in the MHA. The staff we spoke with had a good working knowledge of the MHA.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

None of the patients receiving care and treatment during our inspection were under a deprivation of liberty safeguard.

Staff we spoke to showed good understanding of the principals of the MCA and clinical notes showed that the multidisciplinary team had considered capacity during care reviews. There was evidence of comprehensive mental capacity assessments for some patients. However, we did not find evidence of capacity discussions with patients documented in some care records.

Compliance with mandatory training was low at 35%, against the trust's target of 95%. Senior staff told us the trust did not have sufficient training dates available for staff to attend.

Inadequate

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 ward layouts enabled staff to observe most parts of the ward. Mirrors had been installed in a few of the areas where observation was restricted.
- Conolly ward accepted only male patients and Charlesworth accepted only female patients.Accommodation was on the first floor and consisted mostly of bays containing up to five beds. These areas offered limited privacy and space. There were some single rooms but not all had ensuite facilities. Both wards had shower and bathroom facilities. Furniture was comfortable and in good order.
- Ward 12 was also on the first floor and was a mixed gender ward with male and female areas separated. There was a small crisis suite, for either gender, located in a private area. There were separate lounge facilities for males and females, and furniture was comfortable and in good order. The ward had separate bathroom and shower facilities for males and females. The ward also had two beds for patients referred from the Ministry of Defence. This service was commissioned and staffed separately.
- Charlesworth and Conolly wards shared an outside courtyard area. This was the only outside space available. This area was small and unpleasant. There was one small bench for patients' use. The floor surface of the courtyard was uneven and presented a risk of trips and falls to patients. The trust's ligature audit had identified two risks in this area. However, there was no documented management plan. We found three further ligature risks had not been identified. Nursing staff would escort some patients to use this area, based on individual risk assessment, but staff did not maintain a presence routinely. Nursing staff could not observe the courtyard from the wards and there was no nurse call system in this area for patients to summon assistance if needed. This was a risk for patient safety. We informed the trust of our concerns during the inspection. The trust supplied an action plan to address these concerns.
- The courtyard area used for patients from Ward 12 was large and pleasant. However, there were multiple potential ligature points noted, for example, handrails in the stairwell and garden, and external door handles. Patients could access the courtyard without staff presence. There were management plans for the risks identified, however there was an ongoing risk to patient safety. The trust had made changes to this area to prevent patients from climbing onto the roof, following such incidents. During our subsequent unannounced inspection, senior staff told us that the trust had approved a bid to provide anti-ligature handrails in the stairway leading to the garden.
- Information provided by the trust ahead of the inspection showed that there were no high levels of risk from ligatures for either Charlesworth or Conolly Wards. All wards had up to date ligature risk assessments in place. The trust had plans to replace some of the known risks and others were managed by increased nursing observations. However, some known risks did not have management plans in place. There were ligature points on both wards that had not been identified on the ligature risk assessments, for example, door handles outside the seclusion room on Charlesworth ward. These were identified to senior management and one handle was changed whilst we were on site. Senior staff told us there were plans to change the others immediately.
- On Ward 12, communal areas and bathroom/toilet facilities had anti-ligature fittings. However, the bedroom areas had multiple ligature anchor points in place. These included taps and soap dispensers. Senior staff told us that a request for funding to install anti-ligature fittings in these areas of the ward had been submitted in February 2015, but the trust had not yet completed this work. The bedroom areas had anti-ligature wardrobes installed, however these were not secured to the wall. This was a ligature risk and had not been identified on the risk assessment. During our follow-up unannounced inspection, we observed the trust had responded to the initial inspection findings. Work was taking place to secure the anti-ligature wardrobes to the wall in the male bedrooms and adaptions to the wardrobes in the female dormitory

area had taken place. Staff had reviewed patients' risk assessments. Senior staff were seeking further guidance from the trust risk manager in relation to the adapted wardrobes.

- The seclusion rooms on Conolly and Charlesworth wards were opposite the bed bays. This affected the privacy and dignity of patients. On Conolly ward there was no privacy blind in place. The clock had recently been damaged and not replaced.
- On Ward 12, the seclusion room toilet contained ligature risks. The trust had identified these on the ligature risk audit in January 2015, with plans to replace bathroom fittings and door hinges. The trust had not completed this work and there was no recorded management plan to support staff in the interim. Staff could not observe the toilet area from outside the seclusion room and told us they needed to enter the seclusion room if patients wished to use the toilet, to ensure safety. This affected the privacy and dignity of patients and was a risk to both patients and staff. Senior staff advised there had been an incident recently when staff had been present in the seclusion room. This had required police assistance. The room had two-way communication, an external window and a clock visible from the door. During our follow-up visit, senior staff told us that funding had been approved to make changes to patients' bed areas and the seclusion room; to include installing a privacy panel and anti-ligature fittings for the toilet facilities. The trust planned to complete this work in the New Year.
- There were adequate rooms for care and treatment, and all were clean and appropriately furnished. The latest patient led assessment of the care environment audit showed 98% patient satisfaction in relation to cleanliness. This was higher than the England average, which was 97%. Satisfaction with levels of privacy, dignity and wellbeing were 89%, which was slightly lower than the England average at 90%.
- The clinic rooms were clean and well maintained. Emergency drugs were available, appropriately stored and checked regularly. On Charlesworth ward and Ward 12, nursing staff regularly calibrated and checked all equipment. However, nursing staff had not completed all checks on Conolly ward. Ward 12 stored resuscitation equipment in a central room allowing quick access for staff in an emergency.
- All staff carried personal alarms and there were some nurse call alarm systems in place for patients to use in an emergency. There was no nurse call alarm in the external courtyards, which meant that patients could not summon staff assistance in an emergency or when staff were not present.

Safe staffing

- The wards had a range of staff to deliver care and treatment to patients. These included doctors, nurses, support workers, activity co-ordinators, occupational therapists, administration staff and pharmacists.
- The total establishment of registered nurses for the service was 44 and there were six vacancies. The total establishment of nursing assistants was 45, with one vacancy. Where needed, the trust used bank and agency staff to fill shifts. The trust employed regular bank and agency staff, familiar with the wards, to provide continuity of care to patients. Between May and July 2015, the service reported 523 shifts filled by bank or agency staff. Of these, 229 were on Conolly ward, 107 on Charlesworth and 187 on Ward 12. The wards were unable to fill 212 shifts; the majority of which were on Conolly ward who reported 139 shifts uncovered. In most cases, extra staffing was required to manage higher levels of observations for patients.
- A senior manager reported that staff were becoming tired from covering shift vacancies and that this had led to mistakes, such as nurses forgetting to sign medication cards. Systems were in place to re-deploy staff across the service when needed and examples of this were seen in the duty rotas. During our unannounced inspection on Ward 12, we found sufficient staff for safe care and treatment.
- Ward managers were able to adjust staffing levels to meet the needs of patients. All wards operated a 'safe care' system that identified staffing needs. Staffing levels were calculated via an electronic tablet. This would alert a central team who would book appropriate staff directly. Managers told us that this had reduced nursing time covering required shifts.
- The average staff sickness for the past 12 months was 7% across all three wards: 5% on Charlesworth ward, 10% on Conolly Ward and 6% on Ward 12. This was higher than the average sickness absence for the NHS in England. The total percentage staff turnover for acute

services was 11%, the majority of which had been on Charlesworth ward who reported 7% turnover. The trust reported total staff turnover for the acute services, including non-clinical staff, as 14%.

- All wards operated a 'visible nurse' protocol. An allocated nurse was present in communal areas at all times. This nurse was the first point of contact for all patient enquiries and facilitated leave periods off the ward. The visible nurse allocated contraband items, such as lighters, to patients when they left the ward and ensured that such items returned. Senior staff had updated the visible nurse protocol on Charlesworth ward, following the investigation of a serious incident. However, senior management had not replicated these changes on Conolly ward. The trust had not ensured that changes made, following lessons learned, were implemented on all acute wards. On Ward 12, the visible nurse would allocate swipe cards to patients to allow their access to the building on return from periods of leave. This was risk assessed and worked efficiently.
- There was sufficient staffing to facilitate one to one time with patients and this was reflected in patient notes. Nursing staff would allocate patients a named nurse and associate nurse who oversaw their care whilst in hospital. A notice board identified nurse availability for 'talk time' with patients. Patients reported having time with nursing staff to discuss concerns.
- Senior staff told us they cancelled escorted leave, on occasions, due to staffing levels, particularly when the wards had high levels of activity. Some patients confirmed this. Nursing staff told us leave would often be facilitated during handover periods, when more staff were available.
- Medical staff operated an on-call duty rota to ensure there was adequate medical cover day and night, and a doctor could attend the ward in an emergency.The trust required all staff to complete mandatory training, relevant to their role. The acute service average compliance with training was 81% against the trust's target of 95%. Only 75% of staff were up to date with training in the management of violence and aggression. Therefore, the trust could not be sure that all staff were appropriately trained or refreshed. The lowest level of compliance with mandatory training was for the Mental Capacity Act (MCA), which was 35%. Senior staff advised that they were unable to access training dates for staff as these were fully booked until March 2016. Therefore, the trust could not be sure that staff understood their responsibilities under the Act. All other mandatory training compliance rates were between 43% for food hygiene on Charlesworth ward and 100% for infection control on Ward 12. The trust was not meeting its targets for some mandatory training for acute services staff.

Assessing and managing risk to patients and staff

- In the six-month period to the end of November 2015, there were 90 incidents of seclusion. Seclusion is defined as "the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others." The highest levels of seclusion were on Conolly ward at 42. Charlesworth ward recorded 23 incidents and Ward 12 had 25. Most incidents of seclusion lasted between two and five hours. However, there was evidence of occasions when patients had required seclusion for up to three days. There were no reported incidents of long-term segregation on any of the acute wards.
- Staff had used physical restraint on patients on 160 occasions over the same period. Conolly ward reported 51 episodes of restraint required for 23 different patients. Six patients were restrained in the prone (face down) position. Charlesworth recorded 67 incidents of restraint involving 31 different patients and five prone restraints. Ward 12 recorded 42 incidents of restraint involving 24 patients, of which one required the prone position. This meant that 7% of all restraints were in the prone position. ThePositive and Proactive Care guidance from the Department of Health (2014) states that prone restraint should not be used.
- Staff used verbal de-escalation processes to manage agitated patients. For example, we observed staff on Ward 12 caring for an agitated patient and saw they were compassionate and skilled in their interactions. All staff we spoke with told us they used physical restraint as a last resort. Staff used verbal de-escalation techniques effectively. Records showed minimal use of rapid tranquilisation. During the six-month period to the end of November 2015, there were nine incidents of the use of rapid tranquilisation across all three wards.
- Charlesworth ward operated a 'safe ward' pilot, which included patient access to a 'calm down' box. This box

contained various items designed to reduce agitation and aid stress relief. Patients and staff told us that this was very effective in reducing incidents of aggression and self-harm. Nursing staff told us if patients found items useful they could take these with them when discharged. A local charity would replace these items.

- We viewed the seclusion records for all wards and found these to be appropriately kept and in accordance with the Mental Health Act Code of Practice guidelines. The trust did not have Psychiatric Intensive Care Unit (PICU) facilities and senior staff confirmed there had been occasions when patients had spent protracted periods in seclusion. For example, on Ward 12, staff had secluded a patient for three days whilst the trust secured an appropriate PICU placement. Staff told us there had been occasions when male patients had been secluded on Charlesworth ward, when the seclusion room on Conolly ward was in use or out of action. We did not find a protocol for this.
- During the day, informal patients could leave the ward following a request to the visible nurse. This worked well on all wards. The visible nurse kept a log of patient movements throughout the day. There were appropriate procedures in place for searching patients, subject to individual risk assessments.
- There were differing practices between the wards at The Peter Hodkinson Centre at night. For example, staff were unclear of the process for patient access to the courtyard for fresh air or to smoke during the night. Staff on Conolly ward did not lock the door of the ward and allowed patient access. However, staff on Charlesworth ward locked their ward door and only allowed informal patients to access the courtyard with a staff escort. Staff told us that detained patients could not access outside space during the night, regardless of risk assessment. The trust's operating protocol for managing patient access to designated garden/smoking areas within adult acute care areas did not stipulate when access to this area should cease, however, the protocol for access on and off the ward stated that patients would not have access to the outside space between midnight and six am. Informal patients wishing to access outside space should be risk assessed. The protocol also stated that section 17 leave was not a requirement for access to these areas as they were within ward boundaries. We could not, therefore, understand why access was restricted for detained patients, regardless of risk assessment, or why the two wards operated differently.
- Patients had individualised risk assessments with plans in place to manage risks. For example, the level and frequency of observations of patients by staff could be increased. Overall, the individualised risk assessments we reviewed were detailed and had taken into account the patient's previous history as well as their current mental state. Staff updated assessments at ward reviews, care programme approach meetings or after an incident.
- Compliance with mandatory training for safeguarding was 89%. Ward managers told us that training processes had changed and accessing training was currently problematic. However, each ward had a safeguarding link nurse and staff were able to describe what actions could amount to abuse. The trust provided safeguarding flowcharts for staff reference. Staff were able to apply this knowledge to the patients who used the service and described in detail what actions they would take in response to any concerns.
- There were good processes for the storage, recording and dispensing of medication. Clinic rooms were clean and tidy. Emergency drugs were available and controlled drugs were appropriately stored and recorded in the register. Nursing staff completed a handover sheet after every shift that included checking for medication deliveries and the presence of nursing signatures on dispensing records. Pharmacy and nursing staff completed regular audits, for example, missed dose and missed signature audits. All wards had designated medicine management link nurses who had regular pharmacy link meetings. Pharmacy staff provided annual medicines management training and any medicines incidents were reviewed at the medicines management meetings, as well as at location level. However, 80% of staff were compliant with medicines management and rapid tranquilisation training, against the provider's target of 95%. The lowest compliance with this training was 69% on Conolly ward. All wards received a clinical pharmacy service on weekdays. This ensured that medicines were always available for patients' use.

Inadequate

Are services safe?

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

- The wards had appropriate policies for children visiting and visits were risk assessed as appropriate.

Track record on safety

- Trust information stated that between April 2014 and July 2015 there were 20 serious incidents reported from the acute inpatient wards. This represented 18% of the serious incidents for the trust as a whole. On Charlesworth ward, senior staff had made improvements to the visible nurse protocol following a serious incident. This had not been implemented on Conolly ward. This meant that changes made to improve patient safety were not shared across the site. We observed this protocol to be working well on Charlesworth ward and Ward 12.
- During our follow up inspection, we found the trust had responded to our inspection findings for ongoing patient safety and changes had been made to ligature risks on Ward 12. Senior staff told us changes to the courtyard area at the Peter Hodgkinson Centre were also planned.

Reporting incidents and learning from when things go wrong

- Staff we spoke with could describe the electronic system to report incidents and their role in the reporting process. Each ward had access to an online electronic system to report and record incidents and near misses.
- Staff could describe the various examples of serious incidents that had occurred within the services. The trust told us that there was a local governance process in place to review incidents.
- Recent incidents, outcomes of investigations and identified themes were agenda items at ward team meetings. Minutes of meetings were circulated to staff for reference. There were weekly multi-disciplinary meetings that included a discussion of potential risks relating to patients, and how staff would manage those risks.
- Staff reported varying experiences with de-brief after serious incidents; however most staff felt they were well supported by senior managers when incidents occurred.
- Learning had not always been shared across wards. For example, following a serious incident the 'visible nurse protocol' had been implemented on Charlesworth ward however, senior management had not replicated these changes on Conolly ward.

Are services effective?

Good

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 21 care records for patients receiving care and treatment in the acute wards. Care plans were comprehensive and holistic, and identified a full range of needs and issues. However, on Ward 12 some care plans did not contain patient views. On Charlesworth ward, one patient had not had their risk assessment updated for two weeks, following periods of section 17 leave, and nursing staff had not reviewed two care plans following admission. Most patients had signed their care plan and received a copy.
- Medical staff following the patient's admission to the ward documented physical health examinations and assessments. Patients told us nursing staff monitored their physical health needs on a regular basis and this was evident in patient notes.
- An electronic record system was in use across the trust. Information was shared between the wards, home treatment teams and other community teams. However, some paper records still existed, for example, original copies of Mental Health Act records were stored in paper files on the wards.

Best practice in treatment and care

- The trust had participated in the National Audit of Schizophrenia (NAS2) in 2014. This had highlighted that a high proportion of service users were receiving more than one antipsychotic medication or a higher dose than normally expected. In the acute service, we found evidence of high dose prescribing of antipsychotic medications. For example, eight patients had doses prescribed that were over British National Formulary (BNF) limits on Charlesworth ward and five on Conolly ward. On Ward 12, one patient was prescribed medication above BNF limits, which the pharmacist had highlighted. However, the consultant was not aware of this. All wards prescribed PRN (as required) medication for extended periods without review, and did not always consider the total daily amount for regular and as needed doses. This resulted in potentially high levels of prescribing.
- The wards did not have a psychologist. Nursing staff could refer inpatients to psychology for an assessment. However, treatment would not start until several weeks after discharge. Patients could access 'emotional first aid' groups run every two weeks and the occupational therapist could offer relaxation and mindfulness on Ward 12. Some staff had received solution-focussed training and there were plans to train more.
- The wards used outcome measures, for example, health of the nation outcomes scales and used the scoring to determine the level of need and treatment pathways for patients.
- Nursing staff were actively involved in clinical audit across all three wards. All wards had nursing staff with specific responsibilities, for example, medicines management, moving and handling and infection control. Link nurses conducted audits of their specialist areas.

Skilled staff to deliver care

- Ward staff consisted of nurses, consultants, doctors, occupational therapists, health care support workers, activity co-ordinators, pharmacists and physiotherapy support. This meant that patients had access to a variety of skills and experience for care and treatment.
- New staff underwent a formal induction period to prepare them for their duties.
- Across all three wards, four support workers had completed qualifications in the care certificate and a further three were receiving training. This qualification provided health and social care support workers with the knowledge and skills needed to provide safe, compassionate care.
- All wards held regular team meetings and minutes were kept for staff reference.
- The trust provided data that showed their targets for supervision had not always been achieved. This process identified performance and developmental issues, and allowed staff to discuss concerns with senior colleagues. The average compliance for the past six months was 78%, the highest being 92% in November on Charlesworth ward and the lowest 48% in October on Conolly Ward. Ward
- Ninety-one per cent of all staff had received an appraisal in the last 12 months.

Are services effective?

Good

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.

Multi-disciplinary and inter-agency team work

- All wards held regular multi-disciplinary team meetings. We attended a multi-disciplinary team meeting on Charlesworth ward and observed this was effective in enabling staff to share information about patients and review their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- We observed shift handovers on all wards. These were well structured and detailed.

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

- Sixty six per cent of staff had received training in the Mental Health Act (MHA) and Code of Practice, against the trust target of 95%. This was lowest on Charlesworth ward at 58%. The trust could not be sure that all staff had sufficient training for their role.
- Charlesworth and Conolly wards were using differing paperwork for patients' rights, one of which was out of date.
- Staff completed MHA detention paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. There was a clear process for scrutinising and checking the receipt of MHA paperwork. Overall, MHA record keeping and scrutiny was satisfactory. However, we were concerned that the trust kept original detention papers on the wards, which might pose a risk of loss or damage. MHA paperwork was scanned onto the electronic record for staff reference.
- Medical staff completed consent to treatment and capacity requirements. Nursing staff attached copies to medication charts so that medication was administered in accordance with the MHA.
- Medical staff had not completed leave forms in full, for example, some forms lacked detail in relation to terms and conditions of leave and did not indicate to whom copies had been given. On Conolly ward, patients were advised of their rights under section 132 on admission, but thereafter, staff did not always repeat these in a timely manner.
- One patient had medication prescribed that was not included on their consent to treatment documentation. Nursing staff had not administered this medication.
- On Conolly ward, several records did not indicate whether staff had advised detained patients about their rights to receive support from an independent mental health advocate (IMHA). When the patient was assessed as lacking capacity on admission, we could not see that staff had made further attempts to inform them of the IMHA service. However, posters and leaflets detailing this service were visible on all wards and information was contained in the patients' admission packs. Staff were clear on how to access the service on behalf of patients.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act (MCA) training was mandatory. Thirty five per cent of staff have received this training against the trust target of 95%. The trust could not be sure that all staff were aware of their responsibilities under the Act. Senior staff advised that they had been unable to access training dates for staff, as sessions were fully booked until March 2016.
- Staff we spoke to showed a good understanding of the principles of the MCA. There was some evidence in clinical notes that the multidisciplinary team had considered capacity during care reviews. One patient on Charlesworth ward had thorough assessments of capacity completed for care and treatment; however, we did not always find evidence of capacity discussions with patients documented in care records.
- None of the patients receiving care and treatment during our inspection were under a deprivation of liberty safeguard.

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 21 patients receiving care and treatment across three wards. Feedback from patients was varied. Most patients said there were enough staff providing care and treatment and that staff were caring and respectful.
- We observed staff interactions with patients. Staff were responsive to patient needs, discreet and respectful.
- Staff on Charlesworth ward looking after a patient suffering from terminal illness. This was an unusual and complex clinical picture for an acute admission ward. We observed that staff interactions and management plans were excellent and all required nursing interventions were in place, which included Macmillan nurse support.
- We saw staff working with patients to reduce their anxiety and behavioural disturbance, for example, managing a distressed and agitated patient on Ward 12. This reduced the risk of increased levels of agitation and distress and assisted in maintaining a safe environment.
- We observed good relationships between patients and staff on all three wards.
- Staff were passionate and enthusiastic about providing care to patients with complex needs. They showed a good understanding of the care and treatment needs of patients, for example, re-directing patients towards meaningful activity during periods of agitation and distracting patients away from situations that were stressful to them.
- The latest patient led assessment of the care environment audit showed 89% satisfaction for privacy, dignity and wellbeing for Charlesworth and Conolly wards, and 92% for Ward 12, against the England average of 90%.

The involvement of people in the care that they receive

- All wards had a patient admission pack that included important information about the ward environments, for example, information on the ward philosophy, the staff present on the ward, ward activities, Mental Health Act information and how to complain.
- We received mixed feedback from patients about their involvement in the care they received. For example, two patients on Charlesworth ward told us they were involved in their care plan and had received a copy and one told us they were not. On Conolly ward, two patients had a copy of their care plan and were involved with its review, and two told us they had care plans but did not agree with the content. On Ward 12, two patients told us they were involved in their care plan and had a copy, one told us they had not seen their care plan and one was not sure whether a care plan was in place.
- We received mixed feedback from patients about involvement with advocacy services. Most patients were aware of advocacy but not all had used the service. Posters containing advocacy information and contact details were visible on wards.
- Patients were invited to the multi-disciplinary reviews, along with their family where appropriate.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.

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

- Staff told us that there was often a problem finding beds for patients who needed an admission. Supporting data showed the bed occupancy on the wards was often above 100% capacity. It was frequently necessary to admit patients into the beds of patients who were on short-term leave. The trust information showed the average bed occupancy for the past twelve months was 105%, with Ward 12 and Charlesworth both at 106%, and Conolly at 105%. This confirmed that the trust was using leave beds for admissions. The average length of stay within the acute service over the past 12 months was 34 days.
- Supporting data indicated, at the time of the inspection, there were 27 patients placed in out of area acute beds (that is, beds that were not within the trust's catchment area).
- The trust did not have psychiatric intensive care (PICU) facilities. The trust had plans to provide this facility. The trust referred patients who required a PICU service to other hospitals. Staff told us there could be delays securing a PICU bed, because of funding and transport. The trust had a 72-hour protocol for staff reference. This provided guidance to staff on the safe management of patients awaiting PICU placement. Some staff told us that finding and securing a PICU bed was a stressful process. At the time of the inspection, 11 patients were receiving care and treatment in a PICU.
- Supporting data showed 16 patients were transferred between different acute wards during a single admission in a six-month period. Senior staff told us these transfers were on clinical grounds, for example, to a single sex facility or to nurse the patient closer to their home. We considered these transfers to be appropriate.
- Ward 12 reported the highest amount of delayed discharges over a six-month period at five. These delays were largely due to difficulties securing appropriate accommodation for patients prior to discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients told us they were unable to lock their rooms. This was because much of the accommodation in this core service was dormitory style, with up to five patients sleeping in one dormitory. Curtains were provided between the beds but this did not provide the privacy required. Whilst patients had access to lockable storage space, they did not have the keys for such storage and had to approach a member of staff. This was not based on assessed risk.
- Personalising bedroom areas was difficult because of lack of space. However, we did see notice boards with personal pictures in some areas.
- All wards had access to quiet areas and activity rooms. Ward 12 was particularly spacious. Patients could meet visitors in private and were able to make private phone calls.
- All wards had access to outside space. However, at the Peter Hodgkinson Centre, Charlesworth and Conolly wards shared the same small internal courtyard. This area was used for smokers and non-smokers. There was no means to summon staff in an emergency and nursing staff did not routinely escort patients to this area. There was one small bench available for all patients. The courtyard/garden area for Ward 12 was larger and more pleasant. There was more seating available, but no means to summon staff in an emergency.
- A range of menu choices catered for patients dietary, religious and cultural needs.
- The latest patient led assessment of the care environment audit showed 93% satisfaction with the ward food on Charlesworth and Conolly ward, and 96% on Ward 12. This was higher than the England average at 92%.Patients told us the food was of good quality. However, several patients on all wards commented that the evening meal was sandwiches on white bread. They would prefer a hot meal and two patients commented that they felt this was unhealthy. One patient told us that the housekeeper was attempting to get a choice of bread, but could not provide a hot meal. This did not meet the recommendations of the Hospital Food Standards Panel.
- Some patients complained that they were unable to make hot drinks after midnight; however, others told us that staff would facilitate this when asked.

Are services responsive to people's needs?

Requires improvement

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

- There was a varied activities programme on all wards. Most patients told us they enjoyed the activities; however, one patient on Conolly ward told us that there was not always enough spaces in the activity groups for all patients. Activities were offered at weekends.

Meeting the needs of all people who use the service

- Wards had facilities for disabled patients, to include assisted bathrooms.
- Patient information leaflets were visible on all wards, covering a range of subjects, for example, local services, advocacy and how to complain. Nursing staff could access information in other languages when needed.
- Chaplaincy support was available and some patients used this service.
- Staff told us that interpreters were available using a local interpreting service or language line. Some staff spoke a second language.

Listening to and learning from concerns and complaints

- All the wards accessed the trust's complaints system. Information about the complaints process was available on notice boards and in the welcome packs received by patients on admission. Most patients we spoke with knew how to make a complaint and staff would assist patients when needed.
- Ward managers told us complaints were an agenda item for staff meetings. Minutes detailed how the issues were investigated, the outcomes and lessons learnt.
- From September 2014 to July 2015, there were 11 informal complaints from patients of acute services and 17 formal complaints, of which six were upheld. The top three themes for complaints relate to access to services, care and treatment and communication.
- Over the same period, the acute services received 42 compliments from patients or carers, the largest amount being on Charlesworth ward at 31.

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

- Staff were aware of the trust vision and values, and these were available on the trust's intranet system.
- Staff knew who the most senior managers in the trust were. Staff told us that some senior staff visited the wards.

Good governance

- Supporting data showed staff were 81% compliant with mandatory training requirements overall. However, data for compliance with Mental Capacity Act training was low, at 35%. Senior staff told us they were unable to book staff on this training before March 2016, because all training dates were full. The trust could not be sure, therefore, that staff understood their responsibilities under this Act.
- Supporting data showed an average of 78% compliance with supervision across the acute service, the highest level being on Charlesworth ward at 86%.
- The ward managers confirmed they have sufficient authority to manage their ward and received administrative support. They told us that they received a good level of support from their immediate manager and other senior managers.
- Nursing staff participated in clinical audit, for example, lead nurses for medicines management completed missed dose audits.
- We had concerns about the robustness of the trust's governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Ligature risk assessments and action plans were in place for most risks identified, however, they did not address all ligature risks. For example, the ligature risk audit for the courtyard at The Peter Hodgkinson Centre did not identify all visible ligature risks, as required in the trust's protocol for managing patient access to designated garden/smoking areas. The trust identified an action plan to address these concerns following our inspection. The trust had made changes to communal areas of Ward 12 and reduced ligatures in these areas, but had not addressed ligatures in some high-risk areas, for example, patients' bed areas or the seclusion room toilet facilities. We had sight of a ligature risk audit that identified these risks in January 2015 and these were 'to be replaced' with no interim management plan in place. We were concerned that the trust had taken no action at the time of the inspection. Staff were unable to maintain observations for patients using the toilet and washing facilities. This was a risk to staff and patient safety. However, during our follow up visit to Ward 12, we saw the trust had made some changes and had plans to make other changes in the New Year.
- Following a serious incident, the trust had developed a protocol to address the identified risk however, this had not been implemented across all wards. There were differing practices between wards, for example, two wards had different protocols for access to outside space at night, and between voluntary and detained patients. Different MHA paperwork was in use between wards and some Mental Health Act forms had not been updated following changes to the MHA.

Leadership, morale and staff engagement

- On a day-to-day basis, the wards appeared to be well managed. Staff told us that the ward managers were highly visible on the wards, approachable and supportive. We were impressed with the morale of the staff we spoke with and found that the teams were cohesive and enthusiastic.
- Staff told us that they felt part of a team and received support from each other. They were well supported by their immediate manager and felt they valued their work. Generally, we saw a positive working culture within the teams.
- The ward managers on all wards confirmed that there were no current cases of bullying and harassment involving the staff.
- Staff we spoke with confirmed they understood the whistleblowing process and would feel confident to use it.

Commitment to quality improvement and innovation

- The adult acute inpatient services were committed to the implementation of Royal College of Psychiatrists (RCPsych) AIMS standards. All three wards had achieved

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.

accreditation under this scheme. The acute care clinical specialist occupational therapist was also a member of the RCPsych AIMS Accreditation Committee and RCPsych AIMS Adult Acute In-Patient Advisory Group.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe care and treatment:** The trust are not effectively ensuring that care and treatment is provided in a safe way for patients, by assessing the risks to the health and safety of patients of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. • Wards and courtyard areas had potential ligature points that had not been fully managed or mitigated. • One courtyard had an uneven floor surface. This presented as a trip or fall hazard. • Patients could be unobserved in the courtyard areas and are unable to summon staff assistance if needed. • The seclusion facilities on one acute ward did not have a safe and appropriate environment. **Regulation 12 (1)(2) (a)(b)(d)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing:** Persons employed by the service provider must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

- Staff are not receiving regular supervision to enable ongoing professional development or identification of performance issues.
- Staff are not receiving all mandatory training to enable them to be appropriately trained for their role.

Regulation 18 (2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Meeting nutritional and hydration needs:** The trust must meet any reasonable requirements of a service user for food and hydration arising from the service users' preferences. • The trust must ensure that patients' dietary preferences are met, where reasonable. **Regulation 14 (1)(4)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good Governance:** The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity, and systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services), are not operating effectively. • Systems were in place to identify and manage ligature risks in the patient care areas, for example, we saw evidence of ligature risk assessments and action plans. However, such systems did not identify all the risks relating to ligatures.

This section is primarily information for the provider

Requirement notices

- The trust had failed to ensure that changes made to ward protocols, following lessons learnt were implemented in all areas.

Regulation 17 (2)(b)(f)