South Staffordshire and Shropshire Healthcare NHS Foundation Trust

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

Quality Report

St George's Hospital
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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)
RRE12	St George's Hospital	Brocton House	ST16 3AG
		Chebsey House	ST16 3AG
		Milford House	ST16 3AG

This report describes our judgement of the quality of care provided within this core service by South Staffordshire and Shropshire Healthcare 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 South Staffordshire and Shropshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of South Staffordshire and Shropshire Healthcare NHS Foundation 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 wards had well-equipped clinic rooms with all emergency equipment such as automated external defibrillators and oxygen.
- Staff were trained in safeguarding and demonstrated a good understanding of how to identify and report any abuse.
- There was an effective way of recording incidents, near misses and never events. Staff knew how to recognise and report incidents through the reporting system.
- There were comprehensive assessments that had been completed when patients were admitted. These covered all aspects of care as part of a holistic assessment.
- Patients had access to physical healthcare and had regular physical health checks; including access to specialists when needed.
- There was a full range of mental health disciplines and workers who provided input to the ward. These included psychiatrists, occupational therapists (OT), pharmacist, psychologist, nurses and support workers.
- There was evidence of effective working relationships and external partnership working with the local acute hospital, community learning disability team, independent sector and local authority.
- We observed that staff were kind and caring towards patients and provided positive and emotional support to patients.
- Our observations and discussions with patients confirmed that they had been treated with respect and dignity. Patients were happy about the care they received from staff and felt they got the help they needed.
- Patients were encouraged to involve relatives and friends in care planning if they wished. Patients told us they were involved in meetings about them.
- Patients told us that they were able to access advocacy services when needed.
- Beds were mostly available to people living in the catchment area when needed.
- The wards were well equipped to support treatment and care. There were rooms where patients could sit quietly, relax and watch TV or engage in therapeutic activities.
- Patients had access to relevant information which was useful to them such as treatment guidelines, advocacy, religion, faith and culture.
- Patients told us that they could raise complaints when they wanted to and they were listened to and given feedback.
- Staff knew and agreed with the trusts values. Staff knew who the most senior managers in the trust were and these managers had visited the wards.
- Staff told us that they felt supported by their line managers, worked together well as a team and were offered the opportunities for clinical and professional development courses.
- Staff were offered the opportunity to give feedback on services and input into service development through the annual staff surveys.
- The trust used key performance indicators (KPI) and other indicators to gauge the performance of the wards.

However:

- Staff told us that there often staff shortages which resulted in staff being unable to provide care that met patients' needs adequately. Safer staffing daily reports on Chebsey were indicating level of risk on staffing levels. This was on the trust's risk register and vacancies were being recruited to.
- Brocton and Chebsey staff were used to facilitate section 136 Mental Health Act (MHA) away from the ward. This resulted in reduced staffing levels on the wards.
- Staff from Brocton told us that it was difficult to have regular one-to-one time with their patients because there were not enough staff available to regularly facilitate that.

Summary of findings

- There were no readily available safety alarm systems in place to call for help when needed in Chebsey and Brocton.
- Staff told us that there were no enough computers on the wards, RIO system would often crash and was slow. This was on the trust risk register.
- The audits carried out at trust level such as “when required” (PRN) prescribing and administration were not available on wards so that they were used to identify and address changes needed to improve outcomes for patients.
- Staff supervision was not done consistently on both wards. Most of the staff told us that they did not receive regular supervision.
- Patients told us that there were not enough activities to keep them occupied and they were bored. Staff and patients confirmed that evenings and weekends it was difficult to facilitate activities and there was not much happening to engage patients when the OT was not on duty.
- The information given to senior management was not brought down to managers and staff on the ward to act on where there were deemed to be gaps. Staff and management on wards did not have information that had been analysed for trends and themes to know how the wards were performing.

Summary of findings

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

Are services safe?

- Staff told us that there were often staff shortages which resulted in staff being unable to provide care that met patients' needs adequately. Safer staffing daily reports on Chebsey were indicating level of risk on staffing levels. This was on the trust's risk register and vacancies were being recruited to.
- Brocton and Chebsey staff were used to facilitate section 136 MHA away from the ward. This resulted in reduced staffing levels on the wards.
- Staff and patients told us that at times community leave was cancelled because there was not enough staff on duty.
- Staff told us that it was difficult to facilitate nurse and nursing assistant led activities because of not enough staff on duty.
- Staff from Brocton told us that it was difficult to have regular one-to-one time with their patients because there were not enough staff available to regularly facilitate that.
- In Milford ward one female patient was placed in the bedroom in the male corridor.
- There were no readily available safety alarm systems in place to call for help when needed in Chebsey and Brocton.

However:

- The wards had well-equipped clinic rooms with all emergency equipment such as automated external defibrillators and oxygen.
- There was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency.
- Staff were trained in safeguarding and demonstrated a good understanding of how to identify and report any abuse.
- There were appropriate arrangements for the management of medicines.
- There was an effective way of recording incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to recognise and report incidents through the reporting system.

Summary of findings

Are services effective?

- There were comprehensive assessments that had been completed when patients were admitted. These covered all aspects of care as part of a holistic assessment.
- Patients had access to physical healthcare; including access to specialists when needed. There was evidence of regular physical health checks and monitoring in records.
- NICE guidance was followed when prescribing medication.
- There was a full range of mental health disciplines and workers that provided input to the ward. These included psychiatrists, OT, pharmacist, psychologist, nurses and support workers.
- There was evidence of effective working relationships and external partnership working with local acute hospital, community learning disability team, independent sector and local authority.
- Staff showed a good understanding of the MHA and the Code of Practice and the guiding principles.
- Staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and were able to apply the five statutory principles.

However:

- Staff told us that there were not enough computers on the wards, RIO system would often crash and was slow. This was on the trust risk register.
- There was no evidence of audits conducted at ward level. The audits carried out at trust level such as PRN prescribing and administration were not available on wards so that they were used to identify and address changes needed to improve outcomes for patients.
- Staff supervision was not done consistently on both wards. Most of the staff told us that they did not receive regular supervision.

Are services caring?

- Staff were kind and caring towards patients and provided positive and emotional support to patients.
- Our observations and discussions with patients confirmed that they had been treated with respect and dignity.
- Patients were happy about the care they received from staff and felt they got the help they needed.

Summary of findings

- Patients told us that staff knew them well and supported them in a way they wanted.
- Each patient was provided with information leaflets as a welcome pack to explain and help them understand how the service worked and what to expect.
- Patients were encouraged to involve relatives and friends in care planning if they wished. Patients told us they were involved in meetings about them.
- Patients told us that they were able to access advocacy services when needed.

However:

- Patients were not given copies of their care plans as these were only electronic on RIO.
- Minutes of the community meetings were not documented.

Are services responsive to people's needs?

- Chebsey had an average length of stay of 25 days and Brocton had 40 days from April last year to March 2015.
- Beds were mostly available to people living in the catchment area when needed.
- The wards were well equipped to support treatment and care. There were rooms where patients could sit quietly, relax and watch TV or engage in therapeutic activities.
- There were designated rooms where patients could meet visitors in private away from the patient area.
- Patients had access to relevant information which was useful to them such as treatment guidelines, advocacy, religion, faith and culture.
- Patients told us that they could raise complaints when they wanted to and they were listened to and given feedback.

However:

- Patients told us that there were not enough activities to keep them occupied and they were bored. Staff and patients confirmed that evenings and weekends it was difficult to facilitate activities and there was not much happening to engage patients when the OT was not on duty.

Summary of findings

- Interpreting services were not made available to one patient who did not speak English well enough to communicate when receiving care and treatment.
- Patients told us that they would like more menu choices offered.

Are services well-led?

- Staff knew and agreed with the trust's values.
- Staff knew who the most senior managers in the trust were and these managers had visited the wards.
- Staff told us that they felt supported by their line managers, worked together well as a team and were offered the opportunities for clinical and professional development courses.
- The managers felt they were given the freedom to manage the teams and where they had concerns, they could raise them.
- Staff were offered the opportunity to give feedback on services and input into service development through the annual staff surveys.
- The trust used KPIs and other indicators to gauge the performance of the wards.

However:

- The information given to senior management was not brought down to managers and staff on the ward to act on where there were deemed to be gaps. Staff and management on wards did not have information that had been analysed for trends and themes to know how the wards were performing.
- Some staff in Brocton told us that morale was low with all the changes in staff teams and felt tired and stressed due to staff shortages and working excessive hours.

Summary of findings

Information about the service

Brocton ward is a 20 bedded mixed gender acute mental health ward based at St George's hospital. It provides a twenty four hour service offering assessment, care and treatment for patients who experience complex mental health needs, usually psychosis and severe levels of social and functional impairment. It provides care to people aged between 18 and 65 years who may be detained under a section of the Mental Health Act. 14 of the beds were allocated for acute admissions and six for Ministry of Defence (MoD) personnel. It has separate wings for males, females and MoD. On the day of our inspection the ward had been open for two days following a refurbishment.

Chebsey ward is a 20 bedded mixed gender acute mental health ward based at St George's hospital. It provides a twenty four hour service offering assessment, care and treatment for patients who experience complex mental health needs, usually psychosis and severe levels of social and functional impairment. It provides care to people aged between 18 and 65 years who may be detained under a section of the Mental Health Act. It has two separate wings for males and females. At the time of our inspection the ward was undergoing refurbishment and 12 patients had been temporarily been moved to Milford ward with eight remaining on Chebsey. The two operated as one ward until the refurbishments were completed.

Our inspection team

The inspection team consisted of one expert by experience, four inspectors, one inspection manager and two Mental Health Act reviewers.

Why we carried out this inspection

This was a responsive inspection following concerns raised to us about the acute wards at St George's hospital. We sometimes describe this as a focussed inspection.

This was an unannounced inspection.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited all Chebsey house, Brocton house and Milford house and looked at the quality of the ward environments and observed how staff were caring for patients.
- Spoke with 14 patients who were using the service.
- Spoke with the acting ward sister and ward manager.
- Spoke with 16 other staff members; including doctors, nurses, cleaning staff and occupational therapists.
- Attended and observed one handover and one multi-disciplinary team meeting.

We also:

Summary of findings

- Looked at 14 care records of patients and 12 treatment cards.
- Carried out a specific check of the medication management on each ward.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients were pleased with the care provided. Patients were positive about their experiences of care and told us that staff were polite, kind and interact well with them.

Patients told us that they felt safe and staff were good at their job.

Patients told us that there were not enough activities to keep them occupied.

Patients told us that staff were always busy and do not have enough time with patients for 1:1.

Patients were free to say their views and were taken into account.

Patients told us that staff were very supportive and included them in their care planning.

They were given information that helped them to make choices about their care and treatment.

Patients told us that they felt staff treated them with respect and dignity and listened to.

Good practice

Monitoring of physical health such as vitamin D investigations and joint working with the cardiac department.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that the staffing levels in the wards are adequate and safe at all times to ensure that patients' needs are safely met.

The trust must ensure that all wards have appropriate safety alarm systems in place to ensure that staff are able to call for help when needed.

Action the provider SHOULD take to improve

The trust should ensure that patients are placed in bedrooms of the same gender area.

The trust should ensure that there is a reliable electronic system to manage patients care records.

The trust should ensure that clinical staff are made aware of results of all audits to identify and address changes needed to improve outcomes for patients.

The trust should ensure that all staff receive regular supervision.

The trust should ensure that patients are given copies of their care plans.

The trust should ensure that patients have enough therapeutic activities including evenings and weekends.

The trust should ensure that interpreting services are made available to all patients who did not speak English well enough to communicate when receiving care and treatment.

The trust should ensure that patients have more menu choices offered.

The trust should ensure that information from KPIs that had been analysed for trends and themes is shared with all staff on the wards to ensure that they know how the wards are performing and act on where there are gaps in order to improve services.

South Staffordshire and Shropshire Healthcare 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
Brocton House	St George's hospital
Chebsey House	St George's hospital
Milford House	St George's hospital

Mental Health Act responsibilities

84% of staff in Brocton and 80% in Chebsey had training in the MHA.

Staff showed a good understanding of the MHA and the Code of Practice and the guiding principles.

In Chebsey we looked at four sets of records and there was limited information on how capacity to consent or refuse treatment had been sought. There were no details about sufficient knowledge, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. In Brocton ward patients' files examined for those subject to the three month rule had no evidence that capacity was always assessed when medication was first administered.

There was evidence patients had been given information in accordance with Section 132 of the MHA. However, two patients in Brocton ward told us they had been given a leaflet but no one had gone through this with them.

Administrative support and legal advice on the implementation of the MHA and its code of practice was available from a central team.

Detailed findings

The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant with the MHA and the Code of Practice in all wards.

Staff from all wards knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.

Independent mental health advocate (IMHA) services were readily available to support patients. Staff were aware of how to access and support people to engage with IMHA when needed. However, records in Brocton ward did not always clearly show that detained patients had been informed of their rights to an IMHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw in training records that 83% of staff in Chebsey and 91% in Brocton had received training in the Mental Capacity Act 2005 (MCA).

Staff demonstrated a good understanding of MCA 2005 and were able to apply the five statutory principles.

Patients' capacity to consent was assessed and recorded. These were done on a decision – specific basis with regards to significant decisions. However, there was limited information on how capacity to consent or refuse treatment had been sought for medicines.

Patients were supported to make decisions where appropriate. When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.

Staff understood and where appropriate worked within the MCA definition of restraint.

Staff were aware of the policy on MCA and Deprivation of Liberty Safeguards (DoLS) and knew the lead person to contact about MCA to get advice.

DoLS applications were made when required.

There were arrangements in place to monitor adherence to the MCA within the trust.

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

- Staff told us that there were often staff shortages which resulted in staff being unable to provide care that met patients' needs adequately. Safer staffing daily reports on Chebsey were indicating level of risk on staffing levels. This was on the trust's risk register and vacancies were being recruited to.
- Brocton and Chebsey staff were used to facilitate section 136 MHA away from the ward. This resulted in reduced staffing levels on the wards.
- Staff and patients told us that at times community leave was cancelled because there was not enough staff on duty.
- Staff told us that it was difficult to facilitate nurse and nursing assistant led activities because of not enough staff on duty.
- Staff from Brocton told us that it was difficult to have regular one-to-one time with their patients because there were not enough staff available to regularly facilitate that.
- In Milford ward one female patient was placed in the bedroom in the male corridor.
- There were no readily available safety alarm systems in place to call for help when needed in Chebsey.

However:

- The wards had well-equipped clinic rooms with all emergency equipment such as automated external defibrillators and oxygen.
- There was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency.
- Staff were trained in safeguarding and demonstrated a good understanding of how to identify and report any abuse.
- There were appropriate arrangements for the management of medicines.
- There was an effective way of recording incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to recognise and report incidents through the reporting system.

Our findings

Safe and clean ward environment

- The wards' layout enabled staff to observe most parts of the units effectively. There were some blind spots in Brocton ward in the females' lounge and the MoD lounge.
- Chebsey was in the process of being refurbished to have anti-ligature fittings. There were ligature points on door handles, taps and window latches. Staff were aware of these and the risks were adequately mitigated. For example, staff supervised patients at risk of suicide at all times in areas where there were ligature risks. Ligature audits were completed and actions taken to reduce risks. All staff knew how to use ligature cutters and knew where these were located.
- Brocton ward had recently been refurbished and was fitted with anti-ligature fittings and fixtures. There were potential ligature points on bathroom windows and the garden area. Staff told us that the bathroom windows were scheduled to be fixed. Staff were aware of these and the risks were adequately mitigated. The trust informed us after our visit that this had now been fixed.
- All wards were mixed gender. The wards were divided into separate male and female areas. A female only lounge was provided on the wards. The ward had a shared lounge and dining area. However, in Milford one female patient was placed in the bedroom in the male corridor. Patients had risk assessments that identified any concerns or risks associated with being on a mixed area. The manager told us that patients in the opposite sex corridor were nursed on intermittent observations routinely and an incident form was completed when patients of the opposite sex were placed. Chebsey ward

had seven rooms with en-suite facilities and one single room located next to the bathroom. The bedrooms were located in the same corridor due to refurbishments that were taking place.

- The wards had well-equipped clinic rooms with all emergency equipment such as automated external defibrillators and oxygen. Equipment was checked regularly to ensure it was in good working order so that it could be used well in an emergency. Medical devices and emergency medication were also checked regularly.
- The wards were clean, with good furnishings and were well maintained. Patients told us that the standards of cleanliness were good. However, we noticed that there was a cracked window on the lounge in Brocton and we had been told that this had now been fixed.
- Staff adhered to infection control practices including hand washing. Equipment was clean and stickers notifying that cleaning had taken place were visible and in date.
- Environmental risk assessments were carried out in areas such as health and safety, access to therapy rooms and infection control and prevention. However, the manager in Brocton told us that an environmental risk assessment was not conducted before the patients had moved in.
- There were no readily available safety alarm systems in place to call for help when needed in Chebsey and Brocton. In Brocton there were no nurse call systems installed. This was on the risk register for the trust. The manager told us that the refurbishment would put new safety alarm system in place.

Safe staffing

- Chebsey had 13 qualified nurses and 10 nursing assistants. There was one temporary vacancy for qualified nurse and none for nursing assistants. Brocton had 13 qualified nurses and 10 nursing assistants. There were no vacancies for nursing assistants and qualified nurses.
- Chebsey had one qualified nurse and two nursing assistants for eight patients during the day and one qualified and one nursing assistant at night. Milford operated with two qualified nurses and two nursing assistants for 12 patients during the day and one qualified nurse and two nursing assistant at night. The manager oversaw and worked between the two wards Monday to Friday from 9am to 5pm.
- The manager for Brocton was working night shifts. On the day of our inspection there were two qualified nurses and two support workers on duty from 7am until 3pm, there was another qualified nurse on a shift from 9am to 5pm and the acting ward sister was on a shift from 9am to 5pm to facilitate the electroconvulsive therapy (ECT) clinic. The usual staffing levels were two qualified nurses and two nursing assistants during the day and one qualified and two nursing assistants at night. Five staff told us that there often staff shortages which resulted in staff being unable to provide care that met patients' needs adequately.
- In Brocton there were 372 shifts filled by bank or agency staff to cover sickness, absence or vacancies from 1st April to 18th of June 2015 and in Chebsey there were 239 shifts.
- In Brocton there were 52 shifts that had not been filled by bank or agency where there was sickness, absence or vacancies from 1st April to 18th of June 2015 and in Chebsey there were 26 shifts.
- The sickness rate from April 2014 to March 2015 was 4.5% for Brocton and 4.63% for Chebsey.
- The units had estimated the number and grade of staff required for each unit using Keith Hurst tool. This was monitored through safer staffing system were daily staffing were rated as green when the numbers were adequate. When below the required staffing levels it will be indicated as amber or red. Safer staffing daily reports on Chebsey were indicating level of risk. This was on the trust's risk register and vacancies were being recruited to.
- Brocton and Chebsey staff were used to facilitate section 136 MHA away from the ward. This resulted in reduced staffing levels on the ward. Staff told us that the wards staffing establishment did not enable extra staff to be rostered to facilitate this during the day. Staff were left short on wards as other staff attended the section 136 suite. This was highlighted in the trust risk register and there was no clear plan how this was going to be addressed.

Are services safe?

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

- There was high use of agency and bank nurses to cover sickness, special observations and annual leave. Staff told us that bank and agency staff used were familiar with the wards and the wards tried use the same agency staff. However, there were a lot of new staff in all wards that had been moved around and recruited on temporary basis to cover Milford until the refurbishments were completed.
- The ward manager was able to adjust staffing levels daily to take account of case mix. The manager told us that they were able to adjust staffing resources above their baseline numbers for additional staff to meet the patients' needs. This was where assessed as requiring one-to-one observations.
- Staff and patients told us that at times community leave was cancelled because there was not enough staff on duty. The managers told us that they would try and facilitate most of the leave during handover time where there was more staff and time overlap between two shifts.
- Staff told us that it was difficult to facilitate nurse and nursing assistant led activities because of not enough staff on duty. Patients told us that activities were not taking place during weekends and nights.
- Staff from Chebsey told us that they were able to facilitate one-to-one with patients twice a week and this was monitored. Staff from Brocton told us that it was difficult to have regular one-to-one time with their patients because there were not enough staff available to regularly facilitate this. They told us that they had other duties such as completing notes on RIO there would be one nurse on duty. Four patients from Brocton ward told us that staff on duty were always busy and do not have time with patients. Two patients from Milford told us that staffing was particularly low at night.
- Staff told us they could access medical input day and night and that out of hours a doctor on call was accessible and would arrive on site quickly in an emergency. Each ward had one full time consultant based on the ward, shared one speciality doctor and one foundation doctor.
- Staff received mandatory training and records showed that the average rate was 88% for Brocton and 83% for Chebsey up-to-date with statutory and mandatory training. Staff that were due for updates were booked to attend training.

Assessing and managing risk to patients and staff

- There was no use of seclusion or long term segregation in both wards.
- There were 67 episodes of restraint in Chebsey and 22 in Brocton between April last year and March this year and four were in prone position. From April to June this year there were three episodes of restraint in Chebsey and one in Brocton.
- We looked at records of restraint which clearly indicated how patients were restrained, for example, position, time taken and where each staff member was holding. Restraint was only used after de-escalation had failed. Other methods used prior to restraint were recorded to indicate that it was only used after all other methods had failed. Staff were trained in de-escalation of management intervention (DMI). An incident report was completed following each incident.
- On admission every patient had a 72 hour care plan which was completed by the multidisciplinary team (MDT). This took account of previous history and focused on how the patient would be supported initially for a settling in period as the team got to know the patient. It included the agreed level of observation, risk assessments and a plan of care to manage any identified risks and these were reviewed regularly.
- Staff used a risk assessment tool from RIO system which clearly identified the patient's risks.
- There was information on all the units to let informal patients know that they were able to leave the unit if they wanted to. Informal patients told us they were able to leave the ward unless they agreed with staff that it was unsafe for them to do so.
- There were good policies and procedures for use of observations to manage risk to patients and staff. These were followed by staff and the records were documented consistently. Records indicated the type or frequency of observation, for example, continuous, within eyesight or at arm's length or 15 minutes. Most of the patients told us that they felt safe on the wards.

Are services safe?

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

- The trust rapid tranquilisation policy followed the NICE guidance and had been followed by staff. The use of rapid tranquilisation was rarely used and was audited
- Staff were trained in safeguarding and demonstrated a good understanding of how to identify and report any abuse. Staff knew the trust's designated lead for safeguarding who was available to provide support and guidance. They raised 25 safeguarding referrals in Chebsey and 11 in Brocton from April last year to March 2015.
- Safeguarding issues were shared with the staff team through staff meetings and handovers. Information on safeguarding was readily available to inform patients and staff on how to report abuse.
- There were appropriate arrangements for the management of medicines. Specific monitoring of some medicines was checked by the pharmacist and pharmacy technicians who visited twice a week to ensure safe doses were prescribed. We found good links were in place between the wards and the pharmacy. There was a system to keep a log of stock levels. This was audited and checked by the pharmacist each week when medicines were delivered.
- We reviewed 12 medicine administration records and the recording of administration was complete and correctly recorded as prescribed. The medicines were appropriately stored and the temperatures were regularly monitored. Patients were provided with information about their medicines.

Track record on safety

- There was an incident where a patient died as result of suicide from bed frame ligature. The incident had been reviewed and the trust developed an action plan to address the key issues from the investigation.
- There had been changes recommended to ensure that lessons learnt resulted in changes. The trust replaced all the beds with anti-ligature beds that were fixed to the floor. The current environmental refurbishments were to put fittings and fixtures that were anti-ligature throughout the ward. The changes were rolled out to all wards in the acute.
- Changes were still being made to improve safety standards. This was in response to learning from previous incidents.

Reporting incidents and learning from when things go wrong

- There was an effective way of recording incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to recognise and report incidents through the reporting system. There were 587 incidents reported for Chebsey and 356 for Brocton between April last year and March 2015.
- Staff were open and transparent and explained the outcomes of incidents to patients.
- The wards had a governance framework which reviewed all reported incidents. Incidents sampled during our visit showed that thorough investigations took place, with clear action plans for staff and sharing within the team.
- Staff were able to explain how learning from incidents was rolled out to staff. Their responses indicated that learning from incidents was circulated to staff. Learning from incidents was discussed in staff meetings, reflective practice sessions and handovers.
- Staff were offered debrief and support after serious incidents.

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

- There were comprehensive assessments that had been completed when patients were admitted. These covered all aspects of care as part of a holistic assessment.
- Patients had access to physical healthcare; including access to specialists when needed. There was evidence of regular physical health checks and monitoring in records.
- NICE guidance was followed when prescribing medication.
- There was a full range of mental health disciplines and workers that provided input to the ward. These included psychiatrists, OT, pharmacist, psychologist, nurses and support workers.
- There was evidence of effective working relationships and external partnership working with local acute hospital, community learning disability team, independent sector and local authority.
- Staff showed a good understanding of the Mental Health Act and the Code of Practice and the guiding principles.
- Staff demonstrated a good understanding of MCA 2005 and were able to apply the five statutory principles.

However:

- Staff told us that there were not enough computers on the wards, RIO system would often crash and was slow. This was on the trust risk register.
- There was no evidence of audits conducted at ward level. The audits carried out at trust level such as prn prescribing and administration were not available on wards so that they were used to identify and address changes needed to improve outcomes for patients.
- Staff supervision was not done consistently on both wards. Most of the staff told us that they did not receive regular supervision.

Our findings

Assessment of needs and planning of care

- We looked at 14 records across all units and there were comprehensive assessments that had been completed when patients were admitted. These covered all aspects of care as part of a holistic assessment. Individualised care plans and risk assessments were in place, regularly reviewed and updated to reflect discussions held within the multidisciplinary team (MDT) meetings.
- There was evidence of regular physical health checks and monitoring in records. Staff told us that physical health checks were undertaken. We saw that physical health was discussed and further assessment of these needs had been offered. Where physical health concerns were identified, patients were referred to specialist services and care plans were implemented to ensure that patients' needs were met.
- The care records were up to date, personalised and had recovery-orientated care plans.
- Electronic records within the wards were managed and stored securely using 'RIO' system. Staff's knowledge on the use of the electronic records system was good. Records were organised, and internal team members could access people's records when needed. However, staff told us that there were not enough computers on the wards, RIO system would often crash and was slow. This was on the trust risk register. The management told us that it was something they were looking into to upgrade the system.

Best practice in treatment and care

- NICE guidance was followed when prescribing medication. We saw good examples of this in 10 people's records in all wards.
- Patients could access psychological therapies recommended by NICE as part of their treatment through the psychologists. This was offered to patients who had been assessed for the clinical need and a referral would be made to the psychologists. For example, staff had been trained in cognitive analytical therapy (CAT) to focus on personality disorder patients and this was supervised by the psychologist. The team

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.

followed NICE guidance to avoid delayed discharges. A date of discharge was agreed on admission just to manage crisis, set clear goals and expectations from treatment.

- Patients had access to physical healthcare; including access to specialists when needed. The wards carried out an investigation into patients' vitamin D status and found that 70% of patients were vitamin D deficient and were addressing this. They conducted fasting bloods regularly for metabolic diseases, statins and diabetes. They worked jointly with the cardiac department to monitor the cardiac health of patients.
- Patient's nutrition and hydration needs were assessed and met.
- The wards used a number of outcome measures such as HoNOS, meridian tool, patient feedback questionnaires, Hamilton depression scale and had developed their own in-house tools.
- The medical team were involved in clinical audits such as depression, cardiac health and physical health. However, the nursing team were not involved in regular programme of clinical audits to monitor the effectiveness of the service provided. We were not able to see evidence of audits results on the wards. The audits carried out at trust level such as PRN prescribing and administration, health records and nutrition and hydration were not available on wards so that they were used to identify and address changes needed to improve outcomes for patients.

Skilled staff to deliver care

- The full range of mental health disciplines provided input to the ward. These included psychiatrists, OT, pharmacist, psychologist, nurses and support workers.
- Staff were experienced and qualified. We observed an incident where staff were able to de-escalate effectively patients that presented with aggressive behaviour.
- We saw that community teams and external professionals attended patients' review meetings. For example, social workers and community psychiatry nurses were invited to MDT meetings when required. Patients told us that other professionals who were involved in their care and treatment attended their meetings.
- Staff received appropriate training and professional development. Staff told us they had undertaken training relevant to their role. Staff were trained in CAT, ECT, phlebotomy, electrocardiogram (ECG), medicines management, clinical risk management and physical health assessments. The teams had regular reflective practice sessions specific to the needs of their patients.
- Staff appraisals were 100% in Brocton and 94% in Chebsey. Staff supervision was not done consistently on both wards. Staff told us that they did not receive supervision regularly. The manager told us that they often used reflective sessions as group supervisions.

Multi-disciplinary and inter-agency team work

- We looked at five records of MDT meetings and attended one meeting. The wards had regular involvement of full range of other health professionals such as pharmacist, OT, social workers and psychology. There were regular and effective clinical review meetings that involved the relevant members of the multi-disciplinary team working with the patient.
- There were effective handovers within the teams. They discussed each patient in depth about feedback from review meetings, any changes in care plans, patients' risk management, physical health, community leave, activities and incidents that had occurred.
- There were good working relationships and effective handovers between teams within the trust. Crisis resolution and home treatment (CRHT) and community mental health team (CMHT) worked in partnership with inpatient team to gather information about risks and clinical needs. The teams also worked together to review the risk assessments and crisis plans and to facilitate safe discharge.
- There was evidence of effective working relationships and external partnership working with local acute hospital, community learning disability team, independent sector and local authority.

Adherence to the MHA and the MHA Code of Practice

- 84% of staff in Brocton and 80% in Chebsey had training in the Mental Health Act.
- Staff showed a good understanding of the Mental Health Act and the Code of Practice and the guiding principles.

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.

- In Chebsey we looked at four sets of records and there was limited information how capacity to consent or refuse treatment had been sought. There were no details about sufficient knowledge, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. In Brocton ward patients' files examined for those subject to the three month rule had no evidence that capacity was always assessed when medication was first administered.
- There was evidence patients had been given information in accordance with Section 132 of MHA. However, two patients in Brocton ward told us they had been given a leaflet but no one had gone through this with them.
- Administrative support and legal advice on the implementation of the MHA and its code of practice was available from a central team.
- The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant with the MHA and the Code of Practice in all wards.
- Staff from all wards knew how to contact the MHA office for advice when needed and said that regular audits were carried out throughout the year to check the MHA was being applied correctly.
- Independent mental health advocate (IMHA) services were readily available to support patients. Staff were aware of how to access and support people to engage with IMHA when needed. However, records in Brocton ward did not always clearly show that detained patients had been informed of their rights to an IMHA.

Good practice in applying the MCA

- We saw in training records that 83% of staff in Chebsey and 91% in Brocton had received training in the MCA.
- Staff demonstrated a good understanding of MCA 2005 and were able to apply the five statutory principles.
- Patients' capacity to consent was assessed and recorded. These were done on a decision – specific basis with regards to significant decisions. However, there was limited information on how capacity to consent or refuse treatment had been sought for medicines.
- Patients were supported to make decisions where appropriate. When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the MCA definition of restraint.
- Staff were aware of the policy on MCA and DoLS and knew the lead person to contact about MCA to get advice.
- DoLS applications were made when required.
- There were arrangements in place to monitor adherence to the MCA within the trust.

Are services caring?

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

Summary of findings

- Staff were kind and caring towards patients and provided positive and emotional support to patients.
- Our observations and discussions with patients confirmed that they had been treated with respect and dignity.
- Patients were happy about the care they received from staff and felt they got the help they needed.
- Patients told us that staff knew them well and supported them in a way they wanted.
- Each patient was provided with information leaflets as a welcome pack to explain and help them understand how the service worked and what to expect.
- Patients were encouraged to involve relatives and friends in care planning if they wished. Patients told us they were involved in meetings about them.
- Patients told us that they were able to access advocacy services when needed.

However:

- Patients were not given copies of their care plans as these were only electronic on RIO.
- Minutes of the community meetings were not documented.

Our findings

Kindness, dignity, respect and support

- We observed that staff were kind and caring towards patients. We saw that staff provided positive and emotional support to patients.
- Patients were happy about the care they received from staff and felt they got the help they needed. Our observations and discussions with patients confirmed that they had been treated with respect and dignity and staff were polite and willing to help.
- Staff showed a good understanding of the individual needs and were able to explain how they were supporting patients with different needs. Patients told us that staff knew them well and supported them in a way they wanted.

The involvement of people in the care they receive

- The admission process informed and oriented the patient to the ward and the service. Each patient was provided with information leaflets as a welcome pack to explain and help them understand how the service worked and what to expect.
- Our observation of MDT review meeting, review of records and discussions with patients confirmed that patients were actively involved in their clinical reviews, care planning and risk assessments and were given information about their care. However, patients were not given copies of their care plans as these were only electronic on RIO. Staff told us and patients confirmed that they sat down with staff to discuss their care plans.
- Patients were encouraged to involve relatives and friends in care planning if they wished. Families and carers were invited to clinical reviews and actively involved in care planning where this was appropriate. Patients told us they were involved in meetings about them.
- Staff were aware how to access advocacy services for patients and information was made available to patients. Patients told us that they were able to access advocacy services when needed.
- Staff and patients told us that patients' meetings to gather their views about the service were held regularly and this was led by the OT. However, minutes of the meetings were not documented since March 2015.
- The views of patients were also gathered through the use of patient surveys. Responses to these enabled the wards to make changes where needed.

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

- Chebsey had an average length of stay of 25 days and Brocton had 40 days from April last year to March 2015.
- Beds were mostly available to people living in the catchment area when needed.
- The wards were well equipped to support treatment and care. There were rooms where patients could sit quietly, relax and watch TV or engage in therapeutic activities.
- There were designated rooms where patients could meet visitors in private away from the patient area.
- Patients had access to relevant information which was useful to them such as treatment guidelines, advocacy, religion, faith and culture.
- Patients told us that they could raise complaints when they wanted to and they were listened to and given feedback.

However:

- Patients told us that there were not enough activities to keep them occupied and they were bored. Staff and patients confirmed that evenings and weekends it was difficult to facilitate activities and there was not much happening to engage patients when the OT was not on duty.
- Interpreting services were not made available to one patient who did not speak English well enough to communicate when receiving care and treatment.
- Patients told us that they would like more menu choices offered.

Our findings

Access, discharge and bed management

- The average bed occupancy between April 2014 and March 2015 was 92% for Chebsey and 81% for Brocton. The admission criteria was clearly set out that patients could only be admitted if they had a primary diagnosis of mental illness. People with mild to moderate learning disabilities would be admitted if they met the criteria. All referrals went through the single point of access and the CRHT and CMHT would assess for admission.
- Chebsey had an average length of stay of 25 days and Brocton had 40 days from April last year to March 2015. From April 2015 to May 2015 Chebsey had 22 days and Brocton had 23 days average length of stay.
- Beds were mostly available to people living in the catchment area when needed. The manager told us that there was flexibility with the MoD beds in Brocton. They held MDT meetings every morning and would involve the CRHT and CMHT to assess any patients suitable for discharge and home treatment to accommodate any emergency referrals.
- Patients on leave were able to access their beds on return from Section 17 leave in most cases. The manager told us that there were rare episodes the bed could be occupied and they would follow their flexible system and meetings with CRHT and CMHT.
- Patients were not transferred between wards during an admission episode unless this was justified on clinical grounds and is in the interests of the patient.
- When patients were moved or discharged this happened at an appropriate time of day. The wards worked closely with the CRHT, CHMT and the local authority to ensure that patients were helped through their discharge smoothly. All discharges and transfers were discussed in the MDT meeting and were managed in a planned way.
- The manager told us that if a patient required more intensive care, they would refer to the on-site psychiatric intensive care unit (PICU) first and the beds were not always available. However, if the bed was not available the bed management team would look for a bed elsewhere or patients were delayed for a few days.
- There were eight delayed discharges in Chebsey and 12 in Brocton from April last year to March this year. There was one delayed discharge in Milford since April this year for the patient that was waiting to be assessed by forensic learning disabilities. Staff told us that at times the MOD patients could have delayed discharges due to accommodation not made available for them in the agreed time frame.

Are services responsive to people's needs?

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

The ward environment optimises recovery, comfort and dignity

- The wards were well equipped to support treatment and care. There were rooms where patients could sit quietly, relax and watch TV or engage in therapeutic activities.
- Chebsey and Milford had well-equipped clinic rooms with areas to examine patients.
- The clinic room in Brocton was small and cramped there was no space for an examination couch. There was an examination room off the ward which was equipped with an examination couch. A bedroom on the male bedroom corridor was in the process of being refurbished as a new clinic room which would be large enough to accommodate an examination couch.
- There were designated rooms where patients could meet visitors in private away from the patient area.
- Patients were able to make phone calls in private, some patients had their own mobile phones and they could use them anytime they wanted to in privacy. The patient phone trolley was located on a corridor and did not afford privacy. Staff told us that patients could use a ward phone in the office.
- The wards had access to a secure garden area, which included a smoking area which patients had access to throughout the day.
- Patients were able to personalise their bedrooms.
- Patients told us that the quality of food was good but would like more menu choices.
- Patients had access to hot drinks and snacks 24/7.
- Patients had somewhere secured to store their possessions. Each patient had an individual bedroom fitted with a solid door and an allocated locked cabinet which could be locked.
- There were a range of activities offered to patients by the OT such as art, craft, garden activities and board games. The OT also ran a group therapeutic programme that included music group, cooking, pets as therapy and healthy living. Patients told us that there were not enough activities to keep them occupied and they were bored. We observed that most of the patients were not engaged in activities during our visit, only a few were engaged in board games with staff. Staff and patients confirmed that evenings and weekends it was difficult to facilitate activities and there was not much happening to engage patients when the OT was not on duty.

Meeting the needs of all people who use the service

- There were assisted bathrooms for patients with mobility issues in all wards.
- Information leaflets about the service were available to patients. Staff told us that leaflets in other languages could be made available through patient advice and liaison service (PALS) when needed.
- Staff told us that interpreting services were available when needed to meet the needs of people who did not speak English well enough to communicate when receiving care and treatment. However, we saw that one patient in Chebsey had a family that had requested an interpreter to support with the communication about their care and treatment. There was no evidence to show that the interpreter was made available. Staff told us that family visited regularly and would interpret or they used a domestic worker that spoke the same language as the patient.
- There were information leaflets which were specific to the services provided in all wards. Patients had access to relevant information which was useful to them such as treatment guidelines, advocacy, religion, faith and culture, patient's rights and how to make complaints.
- All wards offered and supported patients with the choice of food they wanted to meet their dietary requirements to meet their religious and ethnic needs. However, one patient from MoD was not able to get their halal food the previous day and this was discussed in the MDT meeting to resolve it.
- There was a chaplaincy service in the hospital which patients could access when they wanted to.

Listening to and learning from concerns and complaints

- There were six formal complaints in Chebsey and five in Brocton in the last 12 months. Three were partially upheld and one was upheld in Chebsey. One was partially upheld in Brocton.
- Information on how to make a complaint was made available to patients including leaflets from PALS.

Are services responsive to people's needs?

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

- Patients told us that they could raise complaints when they wanted to and they were listened to and given feedback. The manager told us and patients confirmed that they could approach staff anytime with their concerns and staff would try to resolve them informally and as quickly as possible.
- Staff were aware of the formal complaints process and knew how to support patients and their relatives to make a complaint following the trust's complaints policy.
- Staff told us that any learning from complaints was shared with the staff team through meetings and handover.

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

- Staff knew and agreed with the trust's values.
- Staff knew who the most senior managers in the trust were and these managers had visited the wards.
- Staff told us that they felt supported by their line managers, worked together well as a team and were offered the opportunities for clinical and professional development courses.
- The managers felt they were given the freedom to manage the teams and where they had concerns, they could raise them.
- Staff were offered the opportunity to give feedback on services and input into service development through the annual staff surveys.
- The trust used KPIs and other indicators to gauge the performance of the wards.

However:

- The information given to senior management was not brought down to managers and staff on the ward to act on where there were deemed to be gaps. Staff and management on wards did not have information that had been analysed for trends and themes to know how the wards were performing.
- Some staff in Brocton told us that morale was low with all the changes in staff teams and felt tired and stressed due to staff shortages and working excessive hours.

Our findings

Vision and values

- Staff knew and agreed with the trust's values.
- Team objectives and values reflected those that the trust promoted.
- Staff knew who the most senior managers in the trust were and these managers had visited the ward.

Good governance

- The trust had governance processes in place to manage quality and safety. The ward managers used these methods to give information to senior management in the trust to monitor quality and safety of the wards. The inspection team identified areas where improvements were needed in regards to adequate staffing levels, staff supervision and personal safety alarms for staff.
- Managers provided data on performance to the trust consistently. All information provided was analysed at each ward level to come up with themes and this was measured against set targets. The managers would attend the trust's quality and safety meetings. However, the information given to senior management was not brought down to managers and staff on the ward to act on where there were deemed to be gaps. Staff and management on wards did not have information that had been analysed for trends and themes to know how the wards were performing, for example number of incidents reported, episodes of restraint and safeguarding. Where performance did not meet the expected standard we did not see that action plans were put in place in the wards.
- The managers from felt they were given the freedom to manage the teams and had administration staff to support the team. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trust's risk register.

Leadership, morale and staff engagement

- There were no grievances being pursued, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the trust's whistleblowing policy. There were mixed feelings about how staff felt free to raise concerns. Staff in Chebsey told us that they felt free to raise concerns and would be listened to. Two staff in Brocton told us that they did not feel free to raise concerns for fear of victimisation.
- Staff told us that they felt supported by their line managers, worked together well as a team and were offered the opportunities for clinical and professional development courses.
- Staff in Chebsey told us that they were a cohesive team with good staff morale. Some staff in Brocton told us that morale was low with all the changes in staff teams

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.

and staff felt tired and stressed due to staff shortages and working excessive hours. However, they all spoke positively about their role and demonstrated their dedication to providing high quality patient care.

- Staff told us that their managers were accessible to staff, had an open culture and willing to share ideas. Staff from Chebsey told us that the managers were approachable. They promoted openness and transparency when things go wrong.
- Staff told us the board informed them about developments through emails and newsletters and sought their opinion through the annual staff surveys.

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 Providers must ensure the safety of their premises and the equipment within it. They should have systems and processes that assure compliance with statutory requirements, national guidance and safety alerts. Staff did not have readily available appropriate personal safety alarm systems in Chebsey and Brocton wards to call for help when needed. This was a breach of Regulation12(2)(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 Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed. Enough staff were not always deployed in all wards at all times to meet the needs of people who used the service. This was a breach of Regulation18(1)