

Requires improvement



Lincolnshire Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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2015
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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)
RP7MB	Beafield Centre	Ashley House	NG31 9DF
RP7QS	Long Leys Road	Discovery House	LN1 1EE
RP7DC	Maple Lodge	Maple Lodge	PE21 0AX

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.

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?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



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 inpatient rehabilitation wards as requires improvement overall because:

- We had serious concerns about leadership and safety.
- There were a number of environmental safety concerns. All services contained ligatures risks, some of which had not been identified or managed. Not all wards met the requirements of single sex accommodation guidance or the Mental Health Act code of practice.
- Staff did not always complete formalised multi-disciplinary admission assessments prior to patients' admission to highlight risks. Not all clinical risk assessments and care plans had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- All rehabilitation services had low staffing, particularly at night. We were concerned that there was insufficient staff to safely manage the service in emergency situations.
- Not all teams were multidisciplinary. Some services had minimal psychological therapies for patients and occupational therapy input. Medical cover was not sufficient.

- Not all services undertook audits to evaluate the outcomes of any of the interventions used on the ward.
- We found that while governance structures were in place these had not always brought about improvement to practices.
- Morale was found to be poor in some areas and some staff told us that they did not feel engaged by the trust.

However:

- Patients told us that staff treated them well and with respect. Staff were observed to be supporting patients appropriately.
- The wards were clean and each patient had their own bedroom. The furnishings were of good quality.
- Procedures for incident management and safeguarding were in place and well used.
- Complaint information was available for patients and staff had a good knowledge of the complaints process.

Summary of findings

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

Are services safe?

We rated safe as inadequate because:

- All services contained ligatures risks, some of which had not been identified or managed. Maple Lodge had many ligature risks. Staff could not provide us with up to date environmental or individual patient risk assessments to mitigate the ligature risks.
- Not all wards met the requirements of single sex accommodation guidance or the Mental Health Act code of practice as male and females were sharing bathroom facilities.
- Staff did not always complete formalised multidisciplinary assessments prior to patients' admission to highlight risks. Not all clinical risk assessments had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- Maple Lodge had three serious incidents of assaults on staff including the attempted strangulation of medical staff. We did not evidence learning from these incidents.
- Most wards had low staffing, particularly at night. We were concerned that there was insufficient staff to safely manage the service in emergency situations.
- There was insufficient medical input across the service.
- Not all staff had undertaken the required mandatory training.

However:

- The wards were clean and each patient had their own bedroom.
- The furnishings were of good quality.
- Patients stated they felt safe on the units.
- Services were managing medication appropriately. Several patients self-administered medication.
- Staff knew how to report incidents appropriately. They were able to give us examples of incidents that required reporting. Discovery House staff confirmed that any incidents were discussed at team meetings and if appropriate at the community meetings.
- Restrictive interventions were not used frequently on the wards and staff were using de-escalation techniques as a first option with patients.

Inadequate



Are services effective?

We rated effective as requires improvement because:

Requires improvement



Summary of findings

- Not all care plans had been undertaken or reviewed meaning patients risks and needs were not always known or addressed. Not all patients were engaged in care planning.
- Maple Lodge and Ashley House did not have a range of therapeutic interventions available on an individual and group basis.
- There was minimal psychological therapies for patients at Ashley House or Maple Lodge.
- Not all services undertook audits to evaluate the outcomes of any of the interventions used on the ward.
- Staff at Maple Lodge did not receive supervision. Maple Lodge had 8% recorded supervision from September 2015 to November 2015.
- Maple Lodge had a limited multidisciplinary team who did not attend ward rounds.

However:

- Clinical staff assessed physical healthcare needs. Patients were able to access emergency care when required through a local GP practice.
- There was good compliance with the Mental Health Act and the Mental Capacity Act procedures.
- Patients' had their rights and informed consent was gained.
- Discovery House ensured all patients had a 'me and my recovery folder' to assist in recording patients journey.
- Staff at Discovery House were trained in dialectic behaviour therapy.

Are services caring?

We rated caring as good because:

- All the wards were calm and relaxed. Staff engaged positively with patients on the ward. Patients told us that staff treated them well and with respect.
- Staff supported patients appropriately.
- Patients told us they had been shown around the unit on admission and received information about the daily routine and the expectations of the service. They told us they were able to attend their ward rounds and care programme approach meetings.

Good



Are services responsive to people's needs?

We rated responsive as good because:

Good



Summary of findings

- The unit provided a trust wide rehabilitation service for patients with long standing mental health needs. The trust's discharge process engaged with the local community mental health teams and external agencies where appropriate.
- Staff had a robust assessment and admission process at Discovery House and Ashley House.
- We saw that patients were able to personalise their rooms. Secure storage areas were available in individual bedrooms.
- Discovery House provided individual activities during the week.
- All areas had quiet rooms, space to meet adult visitors and room space enabled patients to have private meetings with clinical staff.
- Information leaflets were available in a variety of languages.
- There was a process for patients to complain about the service.
- All areas had access to a large outside space.

However:

- There were limited activities available to patients at Ashley House or Maple Lodge.
- Patients stated food at Discovery House was poor.
- Discovery House shared a garden fence with nearby housing estates gardens. This compromised patient's privacy and dignity as neighbours could look into the garden area.

Are services well-led?

We rated well led as requires improvement because:

- Service leads did not ensure good management across the rehabilitation service.
- Maple Lodge did not have a ward manager and limited cover was provided by a band five nurse seconded into a band six post.
- There were no audits in place at Maple Lodge and Ashley House.
- Staff morale was low at Maple Lodge.
- Sickness rates were above national and local targets in all areas except Vale ward at Discovery House.

However

- The rates of staff appraisals was high at 90%.
- Weekly management meetings occurred with relevant ward managers and service leads.

Requires improvement



Summary of findings

Summary of findings

Information about the service

Maple Lodge is in Boston and Ashley House is in Grantham, Lincolnshire. Both provide rehabilitation services to 15 patients, for both males and females within a community setting.

Discovery House, based in Lincoln provides inpatient rehabilitation services on three wards; the Fens, the Wolds and the Vales. The wards provided care and treatment to either male or female patients within either a locked and open environment.

- Fens is a male locked ward with 15 beds.
- Wolds is a male open rehabilitation ward with 15 beds.
- Vale is a female locked ward with 15 beds.

All the wards were full when we inspected.

The service is aimed at enabling individuals to achieve optimum independence levels in a variety of skills in preparation to move to suitable long term accommodation. The wards provide rehabilitation for informal patients and for those detained under the Mental Health Act.

The last Mental Health Act visit across the rehabilitation service was in March 2015, at The Wolds, Discovery House. This raised concerns about capacity to consent to treatment and recording of patients' rights in their records.

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 inpatient rehabilitation wards consisted of two CQC inspectors, a nurse specialist professional advisor and an expert by experience that had experience of using mental health services.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and fair 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 ongoing comprehensive mental health inspection programme

How we carried out this inspection

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

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

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

We carried out an announced inspection visit to the trust between 30 November and 4 December 2015.

During the inspection visit, the inspection team:

- visited three locations, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 25 patients who were using the service
- received 9 comment forms from patients
- interviewed the four ward managers
- met with 13 staff members; including doctors, nurses and occupational therapists
- attended and observed three hand-over meetings and one multi-disciplinary meeting
- reviewed 17 care and treatment records
- carried out a specific check of the medication management on the wards
- reviewed 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 said that staff treated them with respect and dignity.

Discovery House patients reported that they had their rights read and repeated to them and that discharge planning had been discussed with them.

Patients were positive about the service they received. They all self-catered and some administered their own medication which they felt promoted their independence.

Patients at Discovery House said that the food was of very poor quality.

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 and that they do all that is reasonably practicable to mitigate any such risks.
- The provider must ensure that all services meet same sex guidance.
- The trust must ensure there are sufficient staff, including medical staff, to safely manage the service.
- The trust must ensure that clinical staff receive regular supervision.
- The trust must ensure that all patients' risks are assessed and that plans are in place to manage such risks.
- The trust must ensure that patients receive food of a sufficient standard.

Action the provider **SHOULD** take to improve

- The trust should evaluate the outcomes of the interventions used on the wards.
- The trust should formalise their preadmission assessment process at Maple Lodge.
- The trust should review management provision at Maple Lodge.

Lincolnshire Partnership NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ashley House	Ashley House
Discovery House	Long Leys Road
Maple Lodge	Maple Lodge

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.

All detention documentation was clear and contained the relevant information. This included reviews of detention and evidence of tribunals and hearings being held or pending. Patients had received their rights and consent had been sought.

Information about independent advocacy services was available on the ward in patient areas.

Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff had received training in the use of the Mental Capacity Act (MCA). However, staff had a good awareness of the principles of the Act.

Mental capacity and consent to treatment was recorded on the trust's electronic system, including the discussion with the patient and how the responsible clinician reached their decision about capacity.

Detailed findings

Staff had an awareness of where to get advice from within the trust regarding MCA and DoLS. The trust's Mental Health Act administrative team monitored ongoing trust adherence to the MCA.

Are services safe?

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

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

Our findings

Safe and clean ward environment

- All of the wards we visited were clean and well maintained. Generally the furnishings were of a good quality.
- The 'patient led assessment of the care environment audit' (PLACE) scores for cleanliness for all wards were above the England average of 98% with the exception of Ashley House that was at 96%.
- 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.
- The trust told us that all of the wards had been assessed for ligature risks during 2015. At Discovery house we reviewed the assessment and noted that some potential risks had not been included. These included bedroom door handles and a basketball hoop. At Ashley House we observed there to be a large number of ligature risks throughout the ward and garden. Most issues had been identified on the audit and were managed by individual patient risk assessments. However, we noted some risks including curtain tie backs and wardrobe rails that had not been highlighted on the assessment. At Maple Lodge we observed many ligature risks. The trust had told us that the ligature and environmental risks had been assessed in August 2015 however the staff could not provide us with any environmental risk assessments. We were further concerned that patients individual risk assessments, where present, did not address risks that the environment presented.
- All patients within the service had their own bedroom. Discovery House bedrooms were all ensuite. Maple Lodge and Ashley House bedrooms were not all ensuite.
- The trust had told us that there had been no breaches of single sex accommodation guidance. However, Ashley House and Maple Lodge did not comply with same sex guidance from the Department of Health or the Mental Health Act Code of Practice as some patients had to pass bedrooms of another gender to get to toilets and bathrooms. Ashley House had a disabled toilet and

shower room that was not gender specific. Both male and female patients accessed it on a regular basis. Maple Lodge had a disabled toilet with two cubicles that male and female patients could use at the same time.

- Equipment within the units was clean and well maintained. Clinical equipment had service dates clearly displayed and also the dates they were cleaned. Electrical equipment was regularly tested.
- The service had one seclusion room which was located on Vales ward at Discovery House. This met the standards required by the Mental Health Act Code of Practice.
- Staff within Discovery House had individual alarms for use in an emergency. However, this was not the case at Ashley House or Maple Lodge

Safer staffing

- A number of patients expressed concerns about staffing levels. They told us that staff were not always visible or available to support them. Patients also told us that leave could be cancelled due to staffing availability. At Discovery House staff were present in communal areas and engaging with patients throughout the inspection. However, staff were less visible within Ashley House and Maple Lodge.
- The service had set safer staffing levels for the wards and these were met on most occasions. The ward managers had the autonomy to adjust the staffing levels and mix according to the patients' assessed needs. However, we were concerned that staffing was insufficient, particularly on Maple Lodge, Ashley House, the Wolds and the Fens. During the night there were only two staff on duty at both Ashley House and Maple Lodge. Both units were located on standalone sites away from other mental health services. This meant staff would not be able to rely on additional staff support in the event of an emergency. The service worked a split shift system during the day meaning that at times there was just two staff on duty.

Are services safe?

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

- At the time of our inspection the service had a vacancy rate of 13% for qualified nurses. Additional staff told us that they were also leaving the service. Some recruitment had occurred but we heard about difficulties in recruiting experienced staff.
- There are, in total, 5 consultant psychiatrists for the rehabilitation service, covering 75 patients. In Discovery House, there are 4 junior doctors and 3 consultant psychiatrists. In Maple Lodge and Ashley House, there is a named consultant for each (one for Maple and one for Ashley) with junior medical staff support. Each ward has access to a designated junior doctor. The lack of experienced doctors resulted in a very high work-load for the consultant psychiatrists. Given the wide geographical spread of the inpatient services, this also put additional pressures on the consultants.
- The service's overall mandatory staff training rate at October 2015 was 73%, which was below the trust's own target. Immediate life support (85%), safeguarding training (67%), food hygiene (55%) and Mental Capacity Act training (50%) and Mental Health Act (73%) were all below the trust target.
- Staff knew how to report a safeguarding incident and to whom. Training and guidance was available.
- Staff stated that they were aware of the process for raising their concerns and potential whistleblowing within their own team.
- Staff ensured that all medicines were stored, managed and prescribed appropriately. The wards were supported by the trust's pharmacy service. Regular medicine audits were being carried out and the ward had taken action to address any identified concerns. Medicine administration records (MAR) and certificates for treatment were completed appropriately. Medication was prescribed in line with relevant guidelines, with the majority of patients in Ashley House and Maple Lodge on a self-administration of medication programme.

Track record on safety

Assessing and managing risk to patients and staff

- Admissions were pre-planned however, the process varied at the units. Staff at Discovery House and Ashley House completed risk assessments on admission and updated them in ward rounds and care programme approach meetings. While these risk assessments were in place we noted that the quality was variable at some wards. However, staff at Maple Lodge did not complete a formalised multi-disciplinary admission assessment prior to a patient's admission. Risk assessments had not been updated and were not available for all patients. Maple Lodge had three serious incidents of staff being assaulted during 2015 which highlighted that this was not safe practice.
- Restraint was not used frequently on the wards and staff were using de-escalation techniques as a first option with patients.
- Seclusion was only used at Discovery House and was used infrequently. Staff told us that when used this was used it was for the minimum time possible. Seclusion records were completed appropriately and reviews undertaken in line with the MHA Code of Practice.
- Between April 2014 to June 2015, Maple Lodge had three serious incidents of assaults on staff, including the attempted strangulation of medical staff. One serious incident occurred at Discovery House.
- The service had 29 episodes of restraint with 26 occurring at Discovery House from the period January to June 2015. The restraints involved eleven patients. Eight patients were subject to prone restraint, when they were placed on the floor on their front. Three resulted in rapid tranquillisation. This is where medication is given to the patient to assist in calming them down. Guidelines stipulated in Positive and Proactive Care guidance from the, Department of Health (2014) states that prone restraint should not be used.

Reporting incidents and learning from when things go wrong

- Staff knew the process to report incidents appropriately using the trust's electronic incident recording system.
- Discovery House staff confirmed that all incidents that had taken place at on the unit had been discussed at team meetings and, where appropriate, at the community meetings.
- At Discovery House and Ashley House staff said they had been supported following any incidents. However, at Maple Lodge staff did not feel supported following serious incidents.

Are services safe?

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

- At Maple Lodge, there was no evidence of learning from incidents. The rehabilitation service did have a written referral and admission process however this was not robustly followed. There were no multi-disciplinary risk assessments in some patient's records. Given that three patients had seriously assaulted staff at the service a robust risk assessment had not been put in place.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- Discovery House and Ashley House staff had a robust multi-disciplinary team assessment and admission process. Maple Lodge did not have the same.
- The service's admission process stated that patients should have multi-disciplinary care plans, regular care planning meetings and a recovery star, which is a recovery-planning tool. At Discovery House each patient had care plans that were reviewed regularly with their key nurse. Each care plan was individualised. Most patients had a recovery star. Patients felt engaged in their care planning. However, at Ashley House and Maple Lodge not all patients had care plans and few had a recovery star. We did not find evidence that patients had regular care planning meetings. One patient had not had a care programme approach meeting since 2012. Not all patients were engaged in their care planning.
- Discovery House ensured all patients had a 'me and my recovery folder' to assist in recording patients journey, including copies of care plans which were reviewed regularly.
- At all services clinical staff assessed physical healthcare needs. Each patient had a physical health passport at Discovery House. All patients were able to access emergency care when required through a local GP practice.
- An electronic record system was in use across the trust. Information was shared between the wards, home treatment teams and other community teams.

Best practice in treatment and care

- At Discovery House care and treatment records demonstrated personalised care, which was recovery oriented. This was not evident for all patients at Ashley House or Maple Lodge.
- At Vales Ward, at Discovery House, we found good examples of audit of care plans and risk assessment. The unit also used health of the nation outcomes scales

and used the scoring to determine the level of need and treatment pathways for patients. There were no audits or outcome measures evident at Ashley House or Maple Lodge.

- Discovery House provided psychological therapies and audited the effectiveness of them for patients. Some staff had been trained in dialectical behaviour therapy. There were limited psychological therapies for patients at Ashley House or Maple Lodge.
- At Discovery House occupational therapy groups took place from Monday to Friday, with some provided at the weekend. There was minimal occupational therapy input or therapeutic interventions at Maple Lodge.

Skilled staff to deliver care

- Discovery House had a multi-disciplinary team (MDT) which included medical, nursing and occupational therapy staff. However, there was limited psychologist input to treat patients with long-term psychological needs. Vales ward, at Discovery House, had trained five of its nursing staff in dialectical behaviour therapy to help with care and treatment of patients.
- At Maple Lodge the occupational therapist and psychologist attended one day per week (5 hours). Neither were involved in the multi-disciplinary team meetings.
- The clinical strategy set in 2015 had planned to offer staff specialist training in personality disorders and eating disorders. This training was yet to be delivered to staff.
- Staff at Discovery House and Ashley House received regular supervision. Staff at Maple Lodge did not receive regular supervision. Between September 2015 to November 2015 only 8% of staff received supervision at Maple Lodge.
- The staff appraisal rate across the whole service was good at

Multi-disciplinary and inter-agency team work

- Nursing handovers took place between each shift and were effective.

Are services effective?

Requires improvement 

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

- Weekly multidisciplinary ward rounds took place at Discovery House. While weekly ward rounds took place at Ashley House and Maple lodge this were not fully multidisciplinary.
- Occupational therapy and psychology staff attended Maple Lodge for one day per week with neither attending ward round.
- The service had good links with the local authority about safeguarding concerns, and worked closely with community teams and other providers to facilitate community involvement.

Adherence to the MHA and the MHA Code of Practice

- 73% of staff were trained in the Mental Health Act. Staff had a good understanding of the Mental Health Act and the Code of Practice.
- Detention paper work was completed correctly. There was administrative support to ensure paperwork was up to date and held appropriately.
- Staff ensured consent to treatment requirements were met. Consent forms and current medication forms were kept together.
- Staff informed patients of their rights under the Act and documented that patients had consented to treatment.

- Patients had access to independent mental health act advocate (IMHA) services on the wards and the ward had posters and leaflets regarding IMHA services.
- Advocates were regular attendees at Ashley House but not at Discovery House or Maple Lodge. This related to capacity within the advocacy service however advocacy details were on noticeboards in all areas and patients could individually make contact with the service.
- Medical staff did not authorise PRN (as needed) medication on consent forms correctly at Ashley House.

Good practice in applying the Mental Capacity Act

- Training rates for the Mental Capacity Act were low with only 50% of relevant staff trained. However, staff had an understanding of the Mental Capacity Act.
- Staff assessed capacity and consent for individual patients during monthly reviews and recorded this appropriately in patients' notes.
- The staff had an awareness of where to get advice from within the trust regarding the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). One person was subject to DoLS at Maple Lodge. All paper work was completed correctly.
- The trust's Mental Health Act administrative team monitored on-going trust adherence to the Mental Capacity Act.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- Staff engaged positively with patients and wards were calm and relaxed. Patients told us that staff treated them well and with respect. We observed some very positive patient and staff interactions at Vales ward, at Discovery House.
- Staff had an understanding of individual patient need. This was demonstrated through our interviews with staff and our observations of the care and treatment being provided.
- The patient led assessment of the care environment audit (PLACE) scores for privacy and dignity showed 79% for Ashley House and 89% for Maple Lodge which is below the England average of 91%. Discovery House scored 92%.

- We had concerns about the dignity of patients at Ashley House and Maple Lodge due to shared bathroom arrangements.

The involvement of people in the care they receive

- Patients were shown around the units on admission and received information about the daily routine and the expectations of the service.
- Staff at Discovery House ensured that patients were involved in and signed their care plans. This was not the case for all patients at Ashley House and Maple Lodge.
- Patients were encouraged to keep in touch with family and friends and there were appropriate visiting arrangements at all services.
- All wards had regular community meetings.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- The wards provided a trust wide rehabilitation service for patients with long standing mental health needs. The trust had developed a care pathway for the service in 2015.
- The trust's discharge process engaged with the local community mental health team where appropriate. Generally patients were aware of discharge planning arrangements.
- The average bed occupancy at the service was 90% with the Fens highest at 97% and Ashley House lowest at 82%. The average length of stay was 12 months.

The facilities promote recovery, comfort and dignity and confidentiality

- All services had garden areas for patient's recreation. However, the fence at Discovery House was shared with a neighbour, meaning that members of the public could look into the garden. This did not promote privacy on the unit for patients.
- All wards were spacious and had quiet rooms, a room to meet visitors and also a room to have private meetings with clinical staff.
- Wards were equipped to take patients with a physical disability.
- Discovery House provided individual and group activities during the week, and some activities were available at weekends. However, at Ashley House and Maple Lodge there was minimal ward based activities.
- Patients had access to personal mobile phones and pay phones.
- We saw that patients were able to personalise their rooms.
- Secure storage areas were available in individual bedrooms.
- Each ward provided facilities for children to visit relatives.

- All wards attempted to normalise day to day life, especially in the independent flats at Maple Lodge. All patients at Maple Lodge and Ashley House were given a set amount of money to prepare and cook their own meals.
- The PLACE score for food at Discovery House was 82% overall, below the England average of 89%. However, the score for food provided by the organisation was 72% against an England average of 86%. Patients at Discovery House complained about food quality as cooked chilled meals were provided to them. Maple Lodge and Ashley House were self-catering and so did not have a score.

Meeting the needs of all people who use the service

- In 2015 there had been two admissions of an under 18 year old to the service. In these instances the service had ensured that the patients were cared for separately and that child and adolescent service input was provided.
- Staff assisted patients at Maple Lodge and Ashley House with their daily self-catering.
- The ward provided information leaflets and posters on advocacy, complaints procedure and local community activities.
- Information leaflets were available in a variety of languages.
- Staff reported that they were able to access interpreters for patients if required.
- Patients were able to spiritual support as and when required.

Listening to and learning from concerns and complaints

- There was a process for patients to complain about the service.
- From 18 Sept 2014 to 28 July 2015 there had been eight formal complaints with two upheld, and three informal complaints. Themes included care and treatment and staff attitudes. The trust supplied information about the actions taken following the complaints. The service had received 32 compliments during the same period.

Are services responsive to people's needs?

Good 

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

- Wards held daily or weekly meetings, dependant on location, to discuss communal issues and any individual concerns.

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

- At most wards staff were not aware of the trust's vision and values and could not describe them. However, posters promoting the values were on display in all staff areas.
- Staff at Discovery House knew who the directorate senior managers were. However, they did not know who the executive and non-executive directors were.

Good governance

- Weekly meetings were held for ward managers to discuss the running of the service. The meeting looked at operational issues and considered admission and discharge arrangements. However, the meeting did not look at the overall governance of the service.
- Work was underway to look at standardisation of procedures across the service. However, we found that procedures, records systems and information differed from service to service.
- Discovery House and Ashley House staff had a process in place to submit concerns to individual risk registers. Maple Lodge staff were not clear on the process.
- Service leads did not ensure good governance across the service. We had a large number of concerns about the service, particularly at Ashley House and Maple Lodge. The governance systems, including the application of the ligature audit and environmental risk assessments, did not identify all the risks within the units. Where risks were identified by the trust they were not always addressed.
- Other governance systems, including incident reporting and complaints were robust.
- While most staff had an appraisal during the previous 12 months, compliance was supervision was variable and very low at maple Lodge.

Leadership, morale and staff engagement

- Discovery House and Ashley House had good team working, support mechanisms on the ward were evident, and staff felt supported by their immediate managers.
- Maple Lodge had no leadership at a local level. There had not been a substantive manager at the unit for some months and at the time of the inspection, managers had seconded a band five nurse into a band six management post to lead the team.
- Sickness and absence rates ranged from 8.15% on the Wolds to 4.25% on the Vales. Sickness rates were above national and local targets in all areas except Vale ward at Discovery House.
- At the time of our inspection the service had a vacancy rate of 13% for qualified nurses. Additional staff told us that they were also leaving the service. Some recruitment had occurred but we heard about difficulties in recruiting experienced staff.
- Morale was good at Discovery House and Ashley House but there was low staff morale and job satisfaction at Maple Lodge.
- Staff stated that they were aware of the process of raising their concerns and potential whistleblowing within their own team.
- Staff at Discovery House and Ashley House were supported to develop their leadership skills at local level.
- Within the wards there was evidence from interviews with the patient groups that staff were open and honest.

Commitment to quality improvement and innovation

- In October 2014 the rehabilitation service awarded accreditation ratings of excellent.
- The team leader for rehabilitation services at Discovery House was a member of the Royal College of Psychiatrists AIMS rehabilitation peer review team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>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.</p> <ul style="list-style-type: none">• The trust did not comply with Department of Health guidance in relation to mixed sex accommodation at Ashley House or Maple Lodge.• The trust did not adequately identify and manage risks. We found some ligature risks, which were not effectively managed or mitigated.• Staff did not always complete formalised multidisciplinary assessments prior to patients' admission to highlight risks. Not all clinical risk assessments had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.• Maple Lodge had three serious incidents of assaults on staff including the attempted strangulation of medical staff. We did not evidence changes to risk management practice• following these incidents. <p>Regulation 12 (1)(2) (a)(b)(d)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Good Governance:</p> <p>The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who</p>

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Requirement notices

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.

- The trust had failed to ensure that changes to practice were made following lessons learnt from incidents.

Regulation 17 (2)(b)(f)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Staffing

The trust did not deploy sufficient numbers of suitable qualified, competent, skilled and experienced staff to make sure they could meet people's care and treatment needs.

- The rehabilitation services did not include or have access to the full range of mental health professional backgrounds. There was limited occupational therapist or psychologist input in some teams.
- Most wards had low staffing, particularly at night.

We were concerned that there was insufficient staff to safely manage the service in emergency situations.

- There was insufficient medical input across the service.

Regulation 18 (1)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Meeting nutritional and hydration needs:

This section is primarily information for the provider

Requirement notices

The trust must meet any reasonable requirements of a service user for food and hydration arising from the service users' preferences.

- The trust did not ensure that patients' dietary preferences were met, where reasonable.

Regulation 14 (1)(4)(c)