North West Boroughs Healthcare NHS Foundation Trust

Wards for people with a learning disability or autism

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Summary of findings

Wards for people with a learning disability or autism

Summary of this service

North West Boroughs Healthcare NHS Foundation Trust has one ward for people with learning disabilities or autism. Byron ward at Hollins Park Hospital in Warrington provides an assessment and treatment service for adults with a learning disability or autism. It provides inpatient services for adults with a learning disability or autism from the boroughs of Halton, Knowsley, St Helens and Warrington. Byron ward has 12 beds for men and women.

This core service was last inspected in October 2019. The service was rated as requires improvement overall. It was rated inadequate for the effective key question, requires improvement for caring and well-led key questions and good for safe and responsive.

Following the inspection in October 2019, we issued two requirement notices against the effective key question. These were for Regulation 9 (person centred care), and Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On that inspection, we told the trust that they must:

- ensure patients have access to a full multidisciplinary team to enable patients to receive interventions in line with best practice. (Regulation 9)
- ensure that staff follow good practice in relation to assessing and supporting patients with epilepsy and communication needs. (Regulation 9) and
- ensure that training is provided to staff in the specific needs of the patients including learning disability, autism and epilepsy. (Regulation 18).

As a result of these requirement notices, the effective key question was rated as inadequate. This inspection focused on whether improvements had been made in these areas relating to the effective key question.

On the October 2019 inspection, we also told the trust they must ensure they involve carers in the care of their relative by sharing information and inviting them to meetings if consent allows (Regulation 9). We did not look at this aspect of the regulation 9 requirement notice on this inspection as this related to the caring key question.

Our inspection took place on 18 August 2020. It was a short-notice announced, focused inspection (staff knew we were coming approximately an hour before we arrived) to enable us to observe routine activity. On the day of the inspection, there were four patients on the ward and managers told us that five was the maximum number of patients they would have on the ward. As well as looking at the effective key question, we also checked that staff were following patients' positive behavioural support plans and looked at the seclusion arrangements to check that vulnerable patients were not placed in seclusion unnecessarily.

On this inspection we found that the provider had made significant changes and had made improvements to provide effective care and treatment. On this inspection, we found that the provider had met the requirements notices for regulation 9 relating to the effective key question - multidisciplinary working and following good practice. The trust had also made good progress to make sure that training was provided to staff in the specific needs of the patients by December 2020 in order to meet the requirement notice relating to staffing (regulation 18). We did not review the ratings for the effective key question on this inspection as there were other aspects of checking whether the service is effective that we did not look at (such as working within the Mental Health Act and Mental Capacity Act).

We therefore continued to rate North West Boroughs Healthcare NHS Foundation Trust wards for people with learning disabilities or autism as requires improvement.

Summary of findings

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the ward environment and the seclusion room;
- observed how staff were caring for patients;
- spoke with four patients who were using the service;
- spoke with two carers;
- spoke with the ward manager and seven other ward staff members; including a doctor, the occupational therapist, nurses, healthcare assistants, a pharmacist and the activity coordinator;
- spoke with a speech and language therapist and a consultant psychologist from the community learning disability teams;
- attended and observed one handover;
- looked at four care and treatment records of patients; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- We did not review the ratings for the effective key question on this inspection as this was a focused inspection to check whether improvements had been made. There were other aspects of the effective key question that we did not look at.
- In a small number of cases, there were delays in doctors attending seclusion to carry out medical reviews when patients were secluded and staff did not provide fuller or cogent reasons for not meeting this important safeguard as required by the Mental Health Act Code of Practice.

However:

- The provider had taken action to address the shortfalls we found on the last inspection relating to the effective key question.
- Care plans had improved and reflected the assessed needs of patients, including when patients had epilepsy or communication needs.
- The ward now employed an occupational therapist to assess and support patients with self-care, the development of everyday living skills, and to access meaningful activities. Patients now had better access to improved meaningful and rehabilitation activities.
- Although the ward had not managed to employ a designated psychologist, staff and patients were supported by clinical and consultant psychologists from the community learning disability teams.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- Staff continued to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used seclusion only after attempts at de-escalation had failed.

Summary of findings

Is the service safe?

Our rating of safe stayed the same. We rated it as good because:

- This was a focused inspection to check whether improvements had been made. We did not review the ratings for the safe key question.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. As a result, they used seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

However:

- In a small number of cases (3 out of 27 cases), there were delays in doctors attending to carry out medical reviews when patients were secluded. Although staff recorded that the doctor was delayed or did not attend, they did not provide fuller or cogent reasons for not meeting this important safeguard and departing from requirements in the Mental Health Act code of practice.
- While each seclusion episode was audited against the safeguards in the code, audits of episodes of seclusion were not collated to enable managers and clinicians to identify common or emerging themes around seclusion practice and recording.

Is the service effective?

Our rating of effective stayed the same. We rated it as inadequate because:

- This was a focused inspection to check whether improvements had been made. We did not review the ratings for the effective key question on this inspection as we did not cover all the key lines of enquiry.

However, we found the following areas of improvement:

- On this inspection, we found that the provider had met the requirement notice relating to regulation 9 relating to the effective key question - multidisciplinary working and following good practice. The trust had made good progress against their own action plan to make sure that training was provided to staff in the specific needs of the patients by December 2020 in order to meet the requirement notice relating to staffing (regulation 18).
- Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based. Staff had improved written care plans to guide staff when patients had epilepsy or communication needs.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Since the last inspection, the ward employed an occupational therapist to assess and support patients with self-care, the development of everyday living skills, and to access meaningful activities. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Summary of findings

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. Although the ward had not managed to employ a designated psychologist, staff and patients were supported by clinical psychologists from the community learning disability teams.
- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Staff had a good understanding of meeting the needs of patients with learning disability or autism. Some staff had completed specialist training in learning disability, autism and epilepsy through e-learning sessions and took part in reflective practice sessions led by the visiting consultant psychologist. Face to face training had been delayed due to the coronavirus pandemic.

Detailed findings from this inspection

Is the service safe?

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. The seclusion room was part of a de-escalation suite. The seclusion room had a window which let in natural light. However, the blinds were not working. We reported on this following the October 2019 inspection and saw evidence that a repair had been undertaken after the last inspection. We saw that staff had identified it as faulty again through their routine checks and it was reported as another maintenance request in August 2020. Following the inspection, we received written assurance that the blind had been repaired again.

Use of restrictive interventions

Levels of restrictive interventions were reducing. There had been 27 instances of seclusion for the seven-and-a-half-month period between January 2020 and 18 August 2020. The number of incidences was lower than the last time we inspected. On that inspection, this service had 61 incidences of seclusion for 12 months between 1 August 2018 and 31 July 2019.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff had completed positive behavioural support training. Staff had developed an individualised positive behavioural support plan for each patient to a good standard. Records showed that staff tried to use seclusion as a last resort. The trust had a regular least restrictive practice group which discussed and disseminated measures to ensure restrictions for patients were kept to a minimum, which included attendance by the modern matron for Byron ward. All the staff we spoke with (including nursing assistants) were fully aware of the need to keep restrictions to a minimum.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We looked at 22 episodes of seclusion for the seven and a half-month period prior to the inspection. Records showed seclusion was not used frequently, and where it was used it was often used for short periods of less than four hours. The rationale for the use of seclusion was recorded in each case and appeared reasonable – indicating that the patient was secluded following an incident of abnormally aggressive behaviour. Records showed it was used as a last resort and for the shortest time.

Seclusion records showed that the Mental Health Act code of practice safeguards were largely met such as nursing and medical reviews at appropriate intervals. However, in three out of 22 records we looked at, there was no initial medical review. The Mental Health Act code of practice stated that a medical review was usually required within one hour of seclusion starting in most cases. The three records showed that ward staff had requested a medical review straightaway but a medic was not available and did not attend. In these cases, seclusion was for short periods (less than 2 hours for two cases and one case less than 2 hours 30 minutes).

In all three cases, the patient was well known to the ward and seclusion ended prior to a medic attending. While staff recorded that the medic was not available or did not attend in these three cases, fuller cogent written reasons were not given by staff, the doctor and/or at the routine audit review to understand why the doctor could not attend and why the safeguards of the Mental Health Act code of practice were not met in each case.

Following each seclusion episode, staff completed a seclusion audit tool which benchmarked the episode of seclusion against the safeguards of the code and the trust's policy. These were routinely considered and signed off by a manager. However, the details of these audits for each episode of seclusion were not collated into a report or data to look at trends over time to enable managers and clinicians to identify common or emerging themes. Managers were aware of the small number of delays in doctors attending leading to nursing staff to record basic information that medical staff were not available.

Detailed findings from this inspection

There have been no instances of long-term segregation over the 12-month reporting period.

Is the service effective?

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients received medical and clinical assessment to minimise symptoms of their mental ill health through medical input, medication and psychosocial interventions.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward and had an up-to-date hospital passport. Patients had health passports which were updated which provided clear information about any physical health needs or treatment as well as health promotion. Staff ensured that patients received appropriate physical health care including attending primary and secondary medical care appointments. All patients had regular physical health checks.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were individualised, holistic and recovery orientated. Patients had one-profile summaries so that staff and patients could quickly understand patients' needs, likes, dislikes and strengths. Staff completed detailed care plans.

On the last inspection we found that staff need to improve the standard of care plans to manage patients' epilepsy. On this inspection, we found staff had improved their written plans of care to more specifically guide staff on how to address the needs of patients with epilepsy. The care plans included greater detail on the type and frequency of seizures, the specific treatment and the required response and included medical and lifestyle issues.

Staff regularly reviewed and updated care plans and positive behaviour support plans when patients' needs changed. The interventions that staff produced from the care plans were detailed and helped to meaningfully maximise patients' functional ability, self-care and, where possible, patient identified goals. Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and strengths based. Care plans provided clear, individualised information for patients and staff (including new staff) to fully understand what patients' strengths and needs were and how their needs were being met. Staff also provided practical assistance to patients to aid their independence in line with patients care plans. For example, patients were supported with assistance with activities of daily living, such as shopping and cooking.

Positive behaviour support plans were present and supported by a comprehensive assessment. Staff completed a positive behavioural support plan for each patient to a good standard. This helped to guide staff in how patients should be supported and help avoid and manage challenging behaviour.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Detailed findings from this inspection

Staff provided a range of care and treatment suitable for the patients in the service. On the last inspection, patients did not have access to occupational therapy input and activities were limited because of this. Patients now had access to an occupational therapist who supported patients with formal daily living assessments and habilitation (helping the patient learn skills for the first time), rehabilitation and reablement support as well as diversional activities. This included appropriate assessments such as kitchen and road safety assessments. On the last inspection patients could not do some activities because there was no occupational therapist to carry out kitchen assessments. On this inspection, patients commented on the activities they did including cooking – which they were now enabled to do with the occupational therapists. For example, we saw the occupational therapist was working with one patient to habilitate them around cooking using reverse staged cooking methods.

Staff used appropriate communication tools when supporting patients with autism. This included recognising and assessing patients' communication and sensory needs. Since our last inspection, staff had improved written plans of care relating to patients' communication needs. Staff referred patients to and worked with community speech and language therapists where indicated. For example, when patients had more complex communication needs, needed specialist communication equipment or had other needs such as dysphagia (swallowing difficulties). The community speech and language therapist we spoke with indicated that staff referred patients appropriately and communicated with them to develop and adapt communication methods based on the needs of individual patients. We saw an example of where staff offered a patient options of activities in an individualised person-centred way utilising communication techniques relating to their written plan.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg NICE). Staff had improved their written plans of care to more specifically guide staff on how to address the needs of patients with epilepsy. The care plans met the requirements of the National Institute of Health and Care Excellence standards on epilepsy care [Quality Standard Epilepsy in adults (QS26)]. One patient with epilepsy confirmed that staff knew their needs well and they felt safe on the ward.

Relatives were very complimentary about the whole ward team and the effectiveness of the care their relatives received on Byron ward.

Patients had access to psychological therapies through the clinical psychology service based within the community learning disability teams. This meant that patients had access to talking treatments as well as medicine to aid their functioning in line with National Institute for Health and Care Excellence guidance. A consultant psychologist from the community led weekly reflective practice sessions with nursing staff.

Patients with a learning disability or autism had a care and treatment review, in accordance with NHS England's commitment to transforming services for people with a learning disability or autism.

The trust had a learning disability practitioner reference group which met monthly. This was well attended. The reference group were developing pathways and disseminating best practice in aspects of learning disability care including learning disability and dementia care, health equalities, parents with learning disabilities and dysphagia care. Recently the group had considered the consistency of recording the reasonable adjustments different professionals made when providing care and treatment for people with learning disabilities.

Staff provided patients with information in easy read formats. This included both individual patient information and more general information.

Staff understood patients positive behavioural support plans and provided the identified care and support. Staff had worked with patients who presented with behaviours that challenged to produce detailed positive behaviour support plans. Positive behaviour support plans stated the interventions required to change patients' behaviour proactively and manage disturbed behaviour reactively. This was in line with Department of Health recommendations outlined in Positive and Proactive Care: reducing the need for restrictive interventions (2014). Our observations of care showed that staff were following patients' positive behavioural support plans.

Detailed findings from this inspection

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. Staff ensured patients could access dental, chiropody and optician services through patients' health action plans and hospital passports. Patients had access to a designated dietician, physiotherapy and speech and language therapist employed by the trust via referral.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff worked with speech and language therapists and dieticians to address any swallowing or dietary issues. Patients' nutrition and hydration needs were planned, such as when patients were at risk of aspiration requiring specific soft diets or thickened fluids.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital was no-smoking; patients were offered smoking cessation and alternatives to smoking.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Clinicians used Health of the Nation Outcome Scales for People with Learning Disabilities (commonly known as HoNOS-LD) which was a scoring scale to measure the degree of patients' disability and improvements in daily and social functioning.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The ward routinely captured data which was measured against expectations. These included the percentage of patients with a gatekeeping assessment prior to admission, 30-day readmission rates, estimated date of discharge determined and recorded, care programme approach status and HoNOS-LD ratings scale and allergy status recorded. Performance data showed that the ward was performing well in these areas with many areas scoring 100%.

The modern matron and ward leadership team carried out routine audits including audits looking at regular multidisciplinary input, care records (which included care planning, risks assessments, positive behavioural support plans and rating scale recording), infection prevention and control and emergency equipment. For example, the ward audited the levels of multidisciplinary team involvement for each patient – this included looking at:

- the reason for involvement
- the number of visits by each discipline
- the involvement pre-admission
- whether a referral from Byron had been considered and made
- any assessments required and where they are up to
- the number of multidisciplinary team meetings attended for each discipline.

This meant that staff were aware and monitored when and how professionals were involved in each patient's care and treatment.

Managers used results from audits to make improvements. For example, the ward leadership team carried out regular care record audits. The outcomes of the care record audits sometimes identified an action or direction to the named nurse to record or update particular records. We saw evidence that this was raised with individual named nurses to improve records relating to patient's risk screening and care planning records, with evidence that the identified shortfalls were considered and addressed.

The performance and quality of Byron ward was discussed and overseen at the joint Halton and specialist services quality, safety, safeguarding governance meeting. Recent meeting minutes corroborated that quality improvements for Byron ward were considered including progress on action plans, training uptake, medicines management and complaints.

Detailed findings from this inspection

Overall, patients therefore received interventions and staff followed good practice in relation to assessing and supporting patients with epilepsy and communication needs. This meant that the trust had met the requirement notice relating to regulation 9 relating to the effective key question around following good practice and supporting patients with epilepsy and communication needs.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the patients on the ward. Patients were supported by a staff team that included registered mental health nurses, learning disability trained nurses, and experienced nursing assistants. The ward team also consisted of a ward manager and deputy ward manager, two responsible clinicians, junior doctors, an occupational therapist and activities co-ordinator.

The ward had two consultant psychiatrists who also worked out of the community learning disability teams. Relatives were complimentary about the medical input saying the arrangements provided continuity of care and the consultant psychiatrists knew patients well.

The ward had tried to recruit a designated part-time clinical psychologist but there were no appropriate candidates who applied. Managers had therefore reviewed the post to make it more attractive. As an interim measure, clinical psychologists from the community teams worked with patients on an individual basis, providing evidence-based formulation and interventions. Managers were looking at this as a future model of care with community psychology input continuing when patients were admitted promoting continuity of care. This meant that there were sufficient staff deployed to provide care and treatment for patients on the wards.

Managers had made progress to make sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. This included learning disability, autism and positive behaviour support training. Many of the staff on Byron ward had been working there for a number of years and had many years' experience of caring for patients with learning disability and autism. Staff received training in relevant subjects in addition to their mandatory training such as positive behavioural support training, autism awareness and communication training. All staff had received positive behavioural support training.

However face-to-face training had been cancelled or delayed due to the coronavirus pandemic. This meant that not all staff had received specialist training in the specific needs of the patients including learning disability, autism and epilepsy. For example, autism training run by the learning disability training alliance had a compliance rate of 36% prior to the coronavirus pandemic. There were five staff booked onto the next date which would bring compliance to over 60%. The learning disability awareness training compliance was currently 52%. The trust had a target of December 2020 for staff to receive face to face training. Staff had identified or completed other relevant training such as e-learning sessions and received reflective practice sessions led by the visiting consultant psychologist. Staff were knowledgeable about these areas and felt they had benefitted from the reflective sessions. Care plans and other records we saw corroborated this. The trust had therefore made good progress against their own action plan to make sure that training was provided to staff in the specific needs of the patients by December 2020 in order to meet the requirement notice relating to staffing (regulation 18).

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. The overall appraisal uptake rates for last year was 100%. The trust's target rate for appraisal compliance for this year was 90% for permanent non-medical

staff by 30th September 2020. Managers were confident they would also meet the trust target for this year as some staff had received an appraisal in August 2020 and those staff who had not yet received an appraisal were booked prior to the 30th September. Staff we spoke with confirmed they felt very well supported and had either received an appraisal or had one booked.

Managers supported non-medical staff through regular, constructive managerial and clinical supervision of their work.

The trust's target of supervision for non-medical staff was that all staff received managerial supervision every two months and clinical supervision once per quarter as outlined in the trust policy. The average rate across the ward team was 78% of staff receiving managerial supervision as of July 2020 and 64% receiving clinical supervision as of June 2020. This rate would have been higher but five members of staff did not receive supervision due to absence.

Managers monitored supervision and appraisal uptake rates through both borough and the trust governance arrangements.

Medical staff worked mainly in the community learning disability teams. The consultant psychiatrists were community consultants and their support, appraisal and leadership would be provided from this core service. The consultant psychiatrist we spoke with felt well supported and did not raise concern about any aspect of clinical practice.

Managers made sure staff attended regular team meetings or gave information to those that could not attend. Staff confirmed and records of meetings corroborated that staff had the opportunity to meet regularly to discuss the running of the ward.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. A consultant psychologist had led regular weekly reflective practice sessions to support staff to provide evidence-based care to patients and discuss any concerns they had in a non-judgemental, solution-focused way. A summary of discussions showed they included reflective conversations around consistency and continuity of care, pre-admission information and planning, the green light toolkit, individual patient care, seclusion avoidance and the process for the escalation of concerns. The consultant psychologist we spoke with was happy that staff were better engaged and informed.

Managers recognised poor performance, could identify the reasons and dealt with these.

Overall, this meant that staff received support, training, professional development, supervision and appraisal to enable them to meet the specific needs of the patients including learning disability, autism and epilepsy. This meant that the trust had made good progress to meet the requirement notice relating to regulation 18 relating to staffing. However, the trust needed to continue to address face-to-face training uptake rates in some training in line with their own action plan.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Records showed that there was appropriate attendance at these meetings from the various professionals involved in patients' care. The ward team had effective working relationships with other teams in the trust such as community learning disability teams. Staff we spoke to told us that professionals worked well together and ensured patients were at the centre of their discussions.

Staff made sure they shared clear information about patients and any changes in their care, including during the handover meeting. At the handover we observed staff discussing patients' current clinical presentation and anticipated needs.

Detailed findings from this inspection

Ward teams had effective working relationships with other teams in the organisation. We saw that staff worked with other services such as the community learning disability teams and other professionals to provide individualised care and treatment and to facilitate discharge.

Ward teams had effective working relationships with external teams and organisations. We saw that staff referred patients to other services where indicated. For example, staff were ensuring that one patient was receiving appropriate investigations such a computerized tomography scan (CT scan).

Overall, this meant that patients had access to a full multidisciplinary team. This meant that the trust had met the requirement notice relating to regulation 9 relating to the effective key question around multidisciplinary working.

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

We did not look at adherence to the Mental Health Act on this inspection, as the inspection focused on whether improvements had been made following concerns we had when we last inspected.

Good practice in applying the Mental Capacity Act

We did not look at good practice in applying the Mental Capacity Act on this inspection, as the inspection focused on whether improvements had been made following concerns we had when we last inspected.

Areas for improvement

- The trust must continue with efforts to improve staff training uptake rates in line with their stated action plan (produced against the requirement notice relating to staffing issued at the last inspection).
- The trust should continue with efforts to recruit a designated clinical psychologist for Byron ward.
- The trust should ensure that doctors attend an episode of seclusion within one hour of its' commencement in line with the review safeguards set out in the Mental Health Act Code of Practice (and if this is not possible, that doctors properly record the cogent reasons why they are unable to attend).
- The trust should ensure that audits of episodes of seclusion are collated to enable managers and clinicians to identify common or emerging themes around seclusion practice and recording.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one specialist advisor (a nurse) and an expert by experience. Experts by Experience are people who have personal experience of using, or caring for someone who use, health or mental health services.