Midlands Partnership University NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

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

Inadequate ↓↓

Midlands Partnership NHS Foundation Trust was formed on the 1 June 2018 following the acquisition of Staffordshire and Stoke on Trent Partnership NHS Trust by South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

The trust provides mental health and community health services across parts of Staffordshire, Telford and Wrekin and Shropshire. The trust holds national contracts for providing mental health care to the Ministry of Defence. They also have extensive involvement in prisons, substance misuse services and Improving Access to Psychological Therapy services through their Inclusion brand. This gives them a large geographical spread with services stretching from the Isle of Wight to the Yorkshire. The trust is also a major provider of sexual health services commissioned to provide a service in Telford and Wrekin, Shropshire, Leicester City, Leicestershire and Rutland, Stoke-on-Trent and Staffordshire.

We carried out a comprehensive inspection of this trust in February and April 2019 and inspected 9 core services. As a result, the trust was rated as good overall, with safe, caring, responsive and well led rated as good and effective rated as requires improvement.

This inspection was a focussed, unannounced inspection of acute wards for adults of working age and psychiatric intensive care units (PICUs) provided by Midlands Partnership NHS Foundation Trust (MPFT). The inspection was focussed to specific areas of the safe and well-led key questions.

We carried out this inspection following notifications we had received about serious incidents that involved patients from the trust's acute wards for adults of working age during September and October 2022. This included three incidents where patients had taken their own lives during a period of leave from the ward they had been admitted to, and four fire setting incidents that had occurred at The Redwoods Centre. CQC also received concerns in relation to these incidents from Shropshire Fire and Rescue Service, British Transport Police and Staffordshire Police.

The Trust provides acute inpatient wards for adults of working age and PICU's at two locations, St George's Hospital in Stafford and The Redwoods Centre in Shrewsbury. The wards are:

- St George's Hospital, Brocton ward, 20 beds: mixed sex.
- St George's Hospital, Chebsey ward, 19 beds: mixed sex.
- St George's Hospital, Milford ward, 18 beds: mixed sex.
- St George's Hospital, Norbury PICU, 11 beds: male only.
- The Redwoods Centre, Birch ward, 16 beds: mixed sex.
- The Redwoods Centre, Laurel ward, 16 beds: mixed sex.
- The Redwoods Centre, Pine ward, 16 beds: mixed sex.

We previously inspected the trust's acute wards for adults of working age and psychiatric intensive care units (PICUs) in June 2019. The inspection was part of a comprehensive inspection to check on the safety and quality of nine trust services. We rated acute wards for adults of working age and PICU's as good overall, with only one domain, effective,

Our findings

rated as requires improvement. Following the inspection, we told the trust they must ensure managers provide staff with regular one to one supervision that is consistently recorded for personal support, professional development and work performance according to the trust's policy. This was a breach of Regulation 18(2)(a), Staffing of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on the 2 and 3 November 2022, we visited Birch ward and Brocton ward. When we inspected, Birch ward had 16 patients admitted and Brocton ward had 17 patients. Both wards included patients detained under the Mental Health Act 1983. Following the inspection we asked the trust for a range of information and data specific to all 6 acute wards for adults of working age and PICU.

Due to the seriousness of our concerns following our site visits, we used our powers under Section 29A of the Health and Social Care Act 2008 to issue a warning notice to the trust. We use Section 29A warning notices with NHS Foundation Trusts when it appears that the quality of health care provided by the trust requires "significant improvement". The notice provided the trust with a deadline by which they were required to make significant improvement to the areas identified in the notice. Details of the notice can be found at the end of the report under enforcement actions. Following the inspection, the Trust submitted an action plan to address the areas of concern we identified.

Our rating of acute wards for adults of working age and psychiatric intensive care units (PICUs) went down. We rated them Inadequate because:

- The trust relied on temporary staff to maintain safe staffing levels across the acute mental health wards for working age adults and the PICU but could not demonstrate all temporary staff received inductions to the wards they worked on or had easy access to the trust's electronic systems. Incidents demonstrated temporary staff were not always familiar with trust policy and procedural guidance or expectations about staff conduct while working.
- The trust was unable to demonstrate sufficient numbers of staff completed and remained up to date with mandatory training requirements. They also failed to demonstrate sufficient numbers of staff regularly participated in supervisory activities and this had been a requirement from our previous inspection.
- The trust did not meet national guidance to ensure staff had received safeguarding children training to the appropriate level.
- Environmental assessments, including ligature risk assessments and fire safety assessments, were not always sufficient to ensure safety and failed to identify all areas of potential risk and detail actions to reduce the harm from those risks.
- The trust failed to demonstrate how staff always safely managed items of potential risk as part of patients' personal property. This had resulted in incidents of avoidable harm to patients.
- Records failed to demonstrate staff always assessed patient's mental states at the point of taking leave and recorded these discussions and decisions in patients' clinical records
- We saw a significant increase in mixed sex accommodation breaches since our previous inspection and there were concerns about the implications of mixed sex ward environments contributing to sexual safety incidents.
- Challenges around staffing and access to essential information failed to demonstrate processes to share actions and lessons learned following incidents always worked effectively and engaged all staff working within the acute mental health wards for working age adults and the PICU.

How we carried out the inspection

Our findings

During our inspection on the 2 and 3 November 2022, we visited Birch ward and Brocton ward. During the inspection we:

- observed how staff cared for patients;
- spoke with 11 patients who were using the services on Birch ward, Pine ward, Laurel ward and Brocton ward;
- spoke with 22 staff including; nurses, healthcare support workers, matrons, and staff responsible for estates, staffing and budgets;
- reviewed 12 patient care records;
- observed 1 patient meeting;
- met with 2 care groups led by senior staff;
- reviewed a range of policies, procedures and other documents relating to the running of the services.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

During the inspection we spoke with 11 patients; 7 at The Redwoods Centre and 4 at St. George's Hospital. We found patients' feedback and experience differed between the two sites. Patients at St George's Hospital provided positive feedback about staff and said they were kind and respectful, while patients at The Redwoods Centre raised concerns. This included the number of temporary staff deployed on wards, the visibility and accessibility of staff for patients, and staff conduct including sleeping on duty and using inappropriate language. This also appeared to impact on whether patients felt safe and cared for during their stay in hospital. Patients of The Redwoods Centre told us they did not always feel safe during their admission and they found the conduct of staff, particularly temporary staff, was not always respectful, caring and polite.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Environmental risk assessments did not always provide assurance that ward areas remained safe for the patients accommodated on them.

Safety of the ward layout

Staff had not completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The trust had fire safety assessments in place for each ward. However, Shropshire Fire and Rescue Service (SFRS), in October 2022, found the fire safety assessments in place at The Redwoods Centre to be unsuitable and insufficient. They found fire risk assessments did not detail fire incidents that had occurred at the service and failed to identify significant building works with the potential to increase fire risks. They also found that not all fire doors at the location were fitted correctly. SFRS had issued the trust with an enforcement notice detailing how they failed to comply with the Regulatory Reform (Fire Safety) Order 2005 and the actions required to correct the failures.

Our findings

In response to the enforcement notices issued by SFRS, the trust had implemented action plans for the concerns and weekly meetings to monitor the progress of these plans. The meetings were overseen by a member of the trust's senior leadership team.

Between May 2022 and October 2022, the trust recorded 48 fire incidents across their acute wards for adults of working age and PICU. Of these, 85% involved fire activation but did not involve an actual fire. There were 39 incidents recorded at The Redwoods Centre and 9 incidents at St George's Hospital. The incidents identified patients' use of electronic cigarettes in bedroom areas as a common cause of fire alarm activation.

Following the inspection, the Trust submitted an action plan to address the areas of concern we identified together with evidence to demonstrate the delivery of the action plan.

Staff did not complete thorough ligature risk assessments of ward environments to identify potential ligature anchor points and actions to reduce identified risks to patients. Ligature anchor points are fixtures to which people intent on self-harm might tie something to strangle themselves. Both wards we visited had ligature reducing fixtures and fittings in place. The trust's acute wards and PICU had up-to-date ligature risk assessments in place, this was in accordance with the trust's ligature risk assessment standard operating procedure. However, the ligature risk assessments did not routinely assess ward areas identified as either 'locked' or 'supervised'. This commonly included staff toilets, staff offices and storage rooms. This meant staff who worked on the ward would not have had detailed information on how to manage an area of the ward which had potential ligature points. A recent incident in the trust had highlighted patients might still access and be at risk from potential ligature anchor points in areas identified as 'locked' or 'supervised'.

Following the inspection, the Trust submitted an action plan to address the areas of concern we identified together with evidence to demonstrate the delivery of the action plan.

Staff could observe patients in all parts of the wards. The allocation of staff to specific observation tasks including 'garden watch' assisted this.

Wards complied with national guidance and expectations governing the provision of single sex accommodation. All of the trust's acute wards provided mixed sex accommodation for patients. Only the psychiatric intensive care unit (PICU) at St George's Hospital provided single sex accommodation for males. The two acute wards we visited both had clearly separated and defined corridors of sleeping, female only lounges and en-suite accommodation for males and females. However, staff told us that, on occasions, it was necessary to accommodate patients on a corridor of the opposite sex to their own. For example, when we inspected Birch ward, one female patient was accommodated on the male corridor. Staff acted to minimise the time a patient spent accommodated on a corridor of opposite sex to their own and supported them with intermittent observations and specific risk assessments and care plan interventions.

Staff recorded breaches of mixed sex accommodation as incidents. The trust included guidance about delivering same sex accommodation as part of its privacy, dignity and respect policy. Between May 2022 and October 2022, the trust reported 69 mixed sex accommodation breaches in their acute wards, 38 at St George's Hospital and 31 at The Redwoods Centre. This was an increase from our previous inspection, when no mixed sex accommodation breaches had been recorded in a 12 month period between 2017 and 2018. The risk registers of the acute wards at St George's Hospital identified mixed sex accommodation as a risk and provided actions to manage the risk. We did not find mixed sex accommodation identified as a risk in the risk registers of all the acute wards at The Redwoods Centre.

Between May 2022 and October 2022, the trust recorded 158 incidents specific to sexual safety across their acute wards for adults of working age and PICU. This included incidents of assault, verbal threat of sexual assault and sexual

orientation related abuse. Of these 126 were recorded as occurring at The Redwoods Centre and 32 as occurring at St George's Hospital. The trust made sexual safety awareness training available to staff. Wards at St George's Hospital displayed a sexual safety ward charter that detailed expected standards of behaviour. The trust reported a similar charter was being developed for wards at The Redwoods Centre and would be in place by December 2022. In response to a specific incident of sexual abuse at The Redwoods Centre, the local authority highlighted in their response risks and implications for some adults, and particularly females, as a result of mixed sex ward environments.

Records demonstrated staff completed regular portable appliance testing (PAT).

Staff had easy access to alarms and patients had easy access to nurse call systems. During the inspection we saw staff carried alarms and nurse call points in patient's bedrooms and bathrooms. Staff checked alarms and call points to ensure they remained in working order.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. All patients we spoke with told us wards were clean, well maintained and well furnished. This supported our observations during this inspection. Both of the wards we visited were visibly clean and had housekeeping staff in attendance.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2019), both St George's Hospital and The Redwoods Centre scored better than similar locations across England for cleanliness and for condition, appearance and maintenance.

Staff followed infection prevention and control principles (IPC). The trust continued to require staff to wear personal protective equipment (PPE) in ward areas in response to the COVID-19 pandemic. Staff had access to sufficient supplies of PPE, hand sanitiser and waste bins for the disposal of used items. The trust displayed information about using PPE correctly and during the inspection we saw staff doing so. The trust completed regular IPC audits, we saw these included ward cleanliness, waste management and the availability of PPE. Following an IPC audit in September 2022, Birch ward gained a gold award in recognition of a 91% compliance score. The trust required all staff to complete Infection Control (Level 1) training as part of mandatory requirements. However, the overall training completion rate for this service was 80%. Two wards at The Redwoods Centre recorded completion rates of 71% (Pine) and 61% (Birch).

Seclusion room

The Redwoods Centre had non-seclusion areas identified for secluding patients. Non-seclusion areas were behind lockable doors and provided secluded patients with a lounge and bedroom with en-suite facilities. Staff reported safe bedding and clothing was available to support secluded patients. The trust board risk register recorded the practice of secluding patients in non-seclusion rooms created risks to staff safety. For example, doors could be kicked open by patients and staff did not have the ability to withdraw. Managers reported that the need for seclusion had increased due to demand, increased acuity in patients and post the COVID-19 pandemic.

Staff told us a seclusion suite with one bed had recently been built at The Redwoods Centre but was not yet in use to seclude patients, however another seclusion suite was available within the hospital if required. The trust board risk register detailed why use of the completed suite was temporarily delayed and the risks identified with the current practice of secluding patients in non-seclusion rooms remained on the risk register and regularly reviewed.

Our findings

Safe staffing

The service did not always have enough nursing staff deployed, who knew the patients and received basic training to keep them safe from avoidable harm.

Nursing staff

It was not clear that all staffing establishments were always sufficient to meet the needs of the acute wards. The trust used MoHOST which is nationally recognised safer staffing tool. The trust's staffing establishment for registered nurses was similar across The Redwoods Centre and St George's Hospital. However, staffing establishments for unregistered staff varied, with Band 2 staff establishment of 8 at The Redwoods Centre and an establishment of 12 at St George's Hospital. Managers at The Redwoods Centre shared a staffing proposal to increase Band 2 staffing establishment to 14. This had been proposed specifically to reduce reliance on temporary staff locally.

The Redwoods Centre required an establishment of 27.79 WTE Band 5 nurses, of which 17.56 were vacant (63%). This compared with only 10.6 WTE vacant posts at St George's Hospital from an establishment of 39.61 (27%).

Between May 2022 and October 2022, the number of shifts filled by bank or agency staff to cover sickness, absence or vacancies was 1,818 at St George's Hospital and 1,624 at The Redwoods Centre. This accounted for 19% of the total agency use at St George's Hospital and 41% of the total agency use at The Redwoods centre. Evidence provided by the Trust demonstrated that the majority of unfilled shifts were filled by the Trust's Bank staff, many of whom were substantive and experienced employees of the trust covering additional shifts.

The Redwoods Centre relied on agency staff to fill registered nurse hours. In September 2022, agency staff filled 70% of registered staff hours on Laurel ward, 49% of registered staff hours on Birch ward and 16% of registered staff hours on Pine ward. In the same month, wards at St George's Hospital use of agency staff to fill registered staff hours ranged between 10% on Milford ward and 19% on Chebsey ward.

Between April 2022 and September 2022, the staff turnover rate across acute and PICU wards was 11.2%. This was within the trust's control threshold of 10% to 15%.

Between May 2022 and October 2022, the trust used agency staff to cover 5,046 shifts across acute wards and PICU. The Redwoods Centre covered shifts more frequently with agency staff with 3,429 covered by agency compared to 1,617 at St George's Hospital. In the same period the Trust used bank staff to cover 6,798 shifts. St George's Hospital covered shifts more frequently with bank staff, with 5,060 covered by bank compared to 1,738 at The Redwoods Centre.

Acute wards and PICU vacancy rates for both qualified nurses and healthcare support workers were higher at The Redwoods Centre than at St George's Hospital. The Redwoods Centre had a qualified nursing establishment of 42.04 whole time equivalent (WTE) posts of which 18.53 were vacant. At St George's Hospital, of an establishment of 54.61 WTE posts 13.16 were vacant. The Redwoods Centre had a healthcare support worker establishment of 27.20 WTE posts of which 6.12 were vacant (23%). St George's Hospital had an establishment of 57 WTE posts of which only 3.32 were vacant (6%).

Staff recruitment and retention across acute and PICU wards remained challenging. However, the trust had an active programme of recruitment in place alongside specific incentives to attract and retain staff. For example, international recruitment, attendance at recruitment events, relocation packages and training budgets. The trust had also introduced a specific project, "Project Synergy", tasked to address temporary staffing spend and staff concerns regarding recruitment and retention.

Our findings

Managers identified greater recruitment and retention challenge at The Redwoods Centre in part because of its rural location. Locally the trust was creating a new staffing structure to promote leadership, retain experienced staff, and create a career pathway within its acute wards.

In September 2022, the trust reported an annual sickness rate of 9.7% across the acute wards and PICU. The annual sickness rate was highest on Birch ward (13%) and lowest on Milford ward (6.5%). All wards were above the trust's target rate of 4.5%.

Managers planned staffing and always attempted to fill shortfalls created by vacancy, absences and leave. The trust had systems in place to fill staffing requirements firstly with bank staff and then with agency staff if requirements remained unfilled. Staff from the trust's recruitment and temporary staffing departments worked with wards to ensure staffing needs were met. This included twice weekly meetings. Shifts that remained unfilled were escalated beyond the trust's identified main supplier of agency staff. The trust primarily worked with agency supplier affiliated to a framework providing assurances around staff training, competencies and right to work. In exceptional circumstances, some unfilled shifts could be escalated to off framework suppliers but this came at greater expense to the trust and without framework assurances in place. Use of off-framework agency staff was only in place at The Redwoods Centre. Managers told us that whenever possible they used bank or agency staff familiar with the ward they worked on.

Managers told us they could adjust staffing to meet the changing needs of patients admitted to wards. For example, additional staff required for one-to-one patient observations. However, managers identified it was then a challenge to fill that additional staffing requirement. Staff told us that multidisciplinary staff were sometimes required to support safe staffing at ward level. Governance records supported this. Ward manager roles were identified as supernumerary, but routinely supported their wards as part of staffing numbers. Managers identified the need for flexibility and creativity to meet staffing challenges.

Staff routinely identified wards as being short staffed. On the day of our inspection, we found Birch ward to be 2 staff short of planned staffing. Staff felt the quality of care delivery was negatively impacted by staffing challenges and often felt they struggled only to meet the immediate needs of their patients.

We were not assured bank and agency staff always had a full local induction and understood the service before starting their shift. Managers identified staff at site or ward level as responsible for ensuring temporary staff always received a local induction to the ward they worked on. However, staff reported this could not always happen due to the acuity of wards, staffing demands, or a high number of bank or agency staff deployed to a ward or site. It was also unclear where completed local induction records for bank or agency were kept or monitored. Ward staff believed completed local induction records were shared with temporary staffing and temporary staffing believed completed records were kept at ward level. Staff we spoke with were not always assured bank or agency staff were familiar with local policies and procedures to keep patients safe.

It was not clear shifts always had staff with the right mix of skills and experience to meet the needs of patients. Senior staff met daily to discuss staffing, this included reviewing skill mix and experience. However, staff we spoke with identified skill mix and experience as a concern and this was supported by information from other areas including completion rates of mandatory training, completion of staff supervision, oversight of induction processes and reported incidents.

Wards had enough staff on duty each shift to carry out any physical interventions safely. The trust required all temporary staff working on acute and PICU wards to be trained in the management of violence and aggression.

Our findings

During our conversations with patients and staff, some raised concerns about the conduct of some temporary staff. This included staff sleeping during prescribed observations, using mobile phones in clinical areas and using languages other than English to communicate with each other. The trust was aware of concerns and had actions in place. For example, night time spot checks and working restrictions for staff alleged to have fallen asleep on duty. We saw the hospital co-ordinator daily report in place for The Redwoods Centre prompted for any temporary staff issues such as non-attendance or cancellation but didn't specifically prompt for conduct issues.

Mandatory training

Not all staff had completed and kept up-to-date with all their mandatory training. The trust required staff to complete mandatory training and had a target completion rate of 90%. The mandatory training programme was comprehensive to meet the needs of patients and staff.

Staff completion rates failed to demonstrate staff always kept up to date with their mandatory training. As of September 2022, overall mandatory training completion rates ranged from 78% on Birch ward to 88% on Brocton ward which fell below the trust's 90% completion target. However, completion rates for a number of specific mandatory training courses were below 75% compliance and fell below the trust's 90% completion target as of September 2022.

Fire safety training compliance for all 7 wards was between 35% and 74%. Moving and handling training compliance for all 7 wards was between 17% and 67% compliance. Foundation in violence and aggression training for 7 wards was between 64% and 92%; Milford being the lowest compliance and Brocton being the highest compliance.

The trust provided staff with life support training through two courses, Basic Life Support Level 1 and Life Support Level 2. Level 2 was for registered nurses and Level 1 for all other staff. The trust recorded an overall completion rate of 84% for Level 1. The overall completion rate for Level 2 was 73%, with wards at The Redwoods Centre recording 60% completion and at St George's Hospital 82%. Three wards recorded Level 2 completion rates between 56% and 73%, these being Milford, Laurel and Birch.

Three courses on Birch ward did not meet compliance rates; data security training was at 63%, Prevent training was 72% and safeguarding children training was 74%.

Staff completion of mandatory training to manage fire incidents and evacuation was low. Out of 8 fire drills completed in 2022, 3 failed to demonstrate staff competence to manage fire incidents and evacuation. Shropshire Fire and Rescue Service (SFRS) had identified concern about staff training and competence. They had issued the trust with an enforcement notice detailing how they failed to comply with the Regulatory Reform (Fire Safety) Order 2005 and the actions required to correct the failures. In response to concerns about training compliance for Fire Safety Instruction & Evacuation, the trust had arranged additional training. This was initially for staff at The Redwoods Centre, with a plan to include St George's Hospital later. The trust aimed to restore completion rates to 90% or above by March 2023.

The trust also aimed to restore completion of Foundation Violence and Aggression training to 90% or above by March 2023. They identified the negative impact of the COVID-19 pandemic in cancelling face to face training sessions, restricting classroom sizes and preventing staff release from wards to attend training.

The trust had a specific mandatory training action plan in place for Milford ward which reflected the local response to the Trust wide requirement. The plan included action for Fire Safety Instruction & Evacuation, Foundation Violence and Aggression training and Manual Handling training.

Our findings

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us ward staffing requirements sometimes took priority over the allocation of staff to training and development, particularly if training took place externally to the trust. They also told us mandatory training courses delivered face to face did not always run often enough or have enough places available to meet the staff training demand.

Following the inspection, the Trust submitted an action plan to address the areas of concern we identified together with evidence to demonstrate the delivery of the action plan .

Assessing and managing risk to patients and staff

Staff assessed risk well, but did not always manage risks to patients and themselves well when patients went on leave. Staff did not always manage items of risk well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

Assessment of patient risk

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident.

During our inspection we reviewed 12 care and treatment records. All records demonstrated staff completed a risk assessment for each patient at admission. Staff used a recognised risk assessment tool, the Functional Analysis of Care Environments (FACE).

Management of patient risk

Staff did not always act to prevent or reduce risks to patients. Staff did not always identify and respond to any changes in risks to, or posed by, patients.

Staff reported they updated risk assessments regularly, including after significant incidents. Our review of records generally supported this, although we saw one record from each ward where it was not clear staff had updated the risk assessment following an incident.

Staff we spoke with reported clear and consistent practices to manage requests from patients to take leave from the ward. This included checking risk assessments, seeking approval from the nurse in charge and recording specific information including clothing, contact number and the time leave commenced.

However, care and treatment records did not always demonstrate how staff assessed a patient's mental state and risk presentation at the point of taking leave. This included recording the decision made about leave following any assessment. On Birch ward, none of the records demonstrated staff assessed patients and recorded a decision about leave at the point of the patient taking leave. On Brocton ward, four records failed to demonstrate the same. In the two records where an assessment and decision was recorded, staff had recorded sufficient detail to support their decision about the patient taking leave. Managers reported staff did not always record the details of their leave discussions with patients. They identified the need for this to become embedded in routine practice.

It was not always clear how staff acted to manage items of potential risk as part of patient's personal property. This included cigarette lighters and razors. While the trust permitted these items on wards, they required them to be managed and safely stored by ward staff. We saw Brocton ward had a system in place for staff to record when they gave items of potential risk to patients for unsupervised use and when they were returned following use. However, this system did not always appear robust. On the day of our inspection we saw a record of two razors given to a patient by

Our findings

staff at 8.55am. At 3pm, we saw no record of the two razors returned to staff for safekeeping and prompted staff to check their whereabouts. We found the patient had returned the razors, but staff had not updated the record. Birch ward did not have a system in place. Staff did not record when they gave items of potential risk to patients for unsupervised use and when they were returned following use. The trust shared a policy specific to Norbury (PICU) that provided staff there with guidance about the management of items of potential risk as part of patients personal property. However, it was not clear that similar guidance was in place for staff of the acute wards. Following feedback, the trust detailed actions to ensure staff managed items of potential risk safely and consistently.

Similarly, staff practice to manage personal property items of potential risk taken from safekeeping by patients going off of the ward was not always robust. Staff at both locations used a signing-out and signing-in sheet to record when patients went off of the ward. We saw staff recorded when patients went off of the ward and what items they had taken from safekeeping with them. However, the signing-out and signing-in sheet failed to demonstrate staff always ensured items taken off of the ward were returned by the patient for safekeeping. We also found two designs of signing-out and signing-in sheets in use at The Redwoods Centre. One design, wrongly in use by staff from Birch ward, failed to prompt staff to record items of potential risk taken off of the ward and then returned. Staff took action to rectify this when it was brought to their attention.

The trust supported staff with policy and procedural guidance when they needed to search patients or their bedrooms to keep them safe from harm. Staff only carried out searches when there was reasonable grounds to suspect a risk of harm to individuals or others, or on suspicion of criminal activity that would compromise the safety of others. However, it was not clear how the trust was assured all staff were competent to undertake searches or that the practice of staff across all wards was consistent. The policy identified a need for staff to be trained and informed in the use of the search policy. Staff reported they had not received training in how to undertake searches and induction checklists for both substantive and temporary staff did not include information about search policy and procedural guidance. Some staff believed search training was included as part of the trust's managing violence and aggression training, but curriculum details did not support this. Managers reported search training could be accessed from colleagues working within forensic services in response to specific needs or challenges of individual wards.

Practice to ensure all staff were competent to manage environmental risks was not consistent across acute wards and PICU. This included management of ligature risks and management of anti-barricade mechanisms. Staff we spoke with could not always identify how training to manage environmental risks had been delivered, instead reporting that instruction as part of local induction was provided by existing staff. This practice assumed existing staff always knew and demonstrated the correct way to manage these risks. Some wards used an instructional video to support staff learning, but this was not consistent practice across all. Following feedback to the trust, they identified actions to ensure competency amongst existing staff and planned to introduce the management of environmental risks to the trust's managing violence and aggression training.

The trust had policy and procedural guidance in place for the use of observations with patients. Staff told us their competency to complete observations with patients was regularly checked and they felt confident to undertake observations. We saw local induction checklists prompted staff to be aware of the trust's policy and procedural guidance. However, recent incidents demonstrated that agency staff were not always familiar with and did not always follow policy and procedural guidance to complete observations safely.

Following the inspection, the Trust submitted an action plan to address the areas of concern we identified together with evidence to demonstrate the delivery of the action plan.

Our findings

Use of restrictive interventions

Levels of restrictive interventions were low and/or reducing. Between May 2022 and October 2022, the trust recorded 37 incidents of seclusion across their acute wards and PICU. Pine ward, The Redwoods Centre, recorded the highest use with 13 recorded incidents. This was lower than at our previous inspection where 99 incidents of seclusion had been recorded in a 12 month period between 2017 and 2018. Between May 2022 and October 2022, the trust recorded 2 incidents of long-term segregation across their acute wards and PICU.

Between May 2022 and October 2022, the trust recorded 513 incidents of restraint across their acute wards and PICU. Use of restraint ranged from 145 incidents on Laurel ward, The Redwoods Centre, to 20 on Milford ward, St George's Hospital. This appeared in keeping with our previous inspection when 927 incidents of restraint had been recorded in a 12 month period between 2017 and 2018.

Staff managed incidents of restraint to prevent holding patients in the prone position. However, of the 513 recorded incidents of restraint the trust identified 52 incidents of restraint in the prone position (lying facing downwards). Staff used restraint in the prone position only to administer rapid tranquilisation.

Between May 2022 and October 2022, the trust recorded 36 incidents of rapid tranquilisation across acute wards and PICU. This was lower than at our previous inspection where 252 incidents of rapid tranquilisation had been recorded in a 12 month period between 2017 and 2018.

The trust's 'De-escalation, Management and Intervention' (DMI) model and training had been developed and structured to meet best practice standards including the Mental Health Act Code of Practice (2015) and National Institute for Heath and Care Excellence guidance. However, staff completion of training specific to managing violence and aggression fell below the trust's target completion rate.

Staff told us they made every attempt to avoid using physical interventions by using de-escalation techniques and used physical interventions only when these failed and when necessary to keep the patient or others safe.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

The trust had a reducing restrictive practices and interventions strategy in place alongside a restrictive practices policy. The strategy included the trust's ongoing commitment to the 'Safewards' model. The model aims to minimise conflict on wards and maximise safety and recovery. The policy provided staff with guidance on the procedures for restrictive interventions including physical restraint, seclusion and rapid tranquilisation.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Between May 2022 and October 2022, the trust recorded 24 incidents with an adult safeguarding concern across their acute wards for adults of working age and PICU. Of these, wards at The Redwoods Centre recorded 15 and at St George's Hospital 9 incidents.

The incidents recorded demonstrated staff recognised and reported a range of adult safeguarding concerns. Including sexual, psychological and financial abuse. Our conversations with staff further demonstrated this.

Our findings

The trust required staff to complete mandatory training in safeguarding adults and children. The training offered was appropriate to the roles staff held. For example, staff completed safeguarding training to Level 3 for adults and to Level 2 for children. Overall, recorded staff completion rates at September 2022 met or exceeded the Trust's 90% target completion rate, however, Birch ward compliance rate for safeguarding training children, level 2 was 74%.

The trust had a dedicated safeguarding team to support the practice of staff at ward level. The team linked with multi-agency safeguarding boards to make sure staff worked a to locally agreed procedures and understood working arrangements with partner agencies.

The trust had a policy in place to ensure the safety of children visiting services. There were meeting rooms away from wards where visiting children could meet with patients safely. Staff reported a recent incident where an agency member of staff had allowed a child onto an acute ward. The staff member had not been aware of the trust's policies and procedures.

Staff access to essential information

Staff accessed essential information through the trust's electronic systems. However, not all temporary staff routinely had access to electronic systems including those for reporting incidents and policy and procedural guidance

Not all staff had easy access to clinical information, and it was not always easy for them to maintain high quality clinical records. Staff employed by the trust, including bank staff, were issued with usernames and passwords to access the trust's electronic systems. This included patient records, incident reporting and intranet access for policy and procedural guidance. The trust did not routinely make access to electronic systems available to agency staff, although a few registered agency staff block booked to work regularly on wards had been provided with access. As a result, some staff believed there was not always enough information about nursing interventions recorded in patient records. However, the trust had recently introduced a pilot project tasked with providing agency staff with easy access to trust electronic systems, including the intranet and e-learning.

Track record on safety

Between May 2022 and October 2022, the trust recorded 13 serious incidents across their acute wards for adults of working age and PICU. Of these, 5 concerned patients aged under 18 years old admitted to an acute ward for adults of working age and 3 were incidents of patients who were suspected to have committed suicide while away from the ward they had been admitted to.

Between May 2022 and October 2022, the trust recorded 2,483 incidents across their acute wards for adults of working age and PICU. Of these, 1,631 were recorded by wards at The Redwoods Centre and 852 by wards at St George's Hospital.

During this period, Pine ward recorded the highest number of incidents at 687 and Norbury (PICU) the lowest at 129.

The most commonly recorded incident during this period was 'Assault Threats Verbal Abuse' accounting for 768 incidents.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. However, we were not assured established practices to share actions and learning from incidents and investigations remained effective, particularly given the impact of staffing challenges and the reliance on temporary staff.

Our findings

Staff confirmed they knew what incidents to report and how to report them. The trust had an electronic system in place for reporting incidents. Some staff expressed concern that agency staff lacked routine access to trust electronic systems, and this was a barrier to ensuring all incidents that occurred were reported. They identified particular concern on occasions where shifts were predominately staffed by agency.

The trust recorded no 'never events' across their acute wards for adults of working age and PICU. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Managers debriefed and supported staff after any serious incident. Staff confirmed managers debriefed and supported staff after any serious incident. Where necessary, this included psychological support. Staff provided examples of temporary staff being invited to attend for debrief and support.

Staff reported serious incidents clearly and in line with trust policy. The trust required reported incidents to be investigated. Managers identified some challenge to thoroughly investigating incidents where agency staff had been involved. As the trust did not routinely hold the contact details of agency staff, managers reported some challenge to contacting and engaging agency staff in incident investigations.

The trust had established processes through which actions and learning from incidents were shared with staff. This included handovers, team meetings, supervision, updates to clinical records and email communications. However, it was not clear these processes always worked well. For example, staff told us planned team meetings did not always happen, not all staff had easy access to emails or clinical records, and staff participation in recorded supervision activities remained low. Managers did not always feel assured agency staff acted on information shared at handovers or were familiar with trust policy and procedural guidance. Recent fire setting incidents supported this position.

The trust met monthly with its main supplier of agency staff and this meeting included discussion of incidents that occurred in the trust and learning from those incidents. The trust could request the agency supplier to share messages with agency staff, for example, the responsibility of agency staff to arrive on time for their shift. However, it was the responsibility of ward staff to share actions and learning from incidents with agency staff.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

We saw evidence of trust investment in leadership to support wards.

The trust had invested in additional leadership roles on their acute wards and PICU to support the skill mix and experience of ward teams. The trust supported staff with leadership development opportunities.

Staff spoke positively about the matrons in place at both The Redwoods Centre and St George's Hospital. They described them as visible in the service, approachable and supportive.

Our findings

Culture

Staff experience of feeling respected, supported and valued was different between the two wards we visited. The trust had established whistle-blowing processes and Speak Up Guardian roles. Staff believed the trust valued staff speaking up and felt able to raise concerns without fear of retribution.

Those staff we asked about feeling respected and valued responded positively. The trust completed regular opinion surveys with staff. The trust included actions resulting from staff opinion surveys as part of care group transformation plans, so were not specific to the wards we inspected.

Staff from Brocton ward reported feeling happy and positive working within their team. This was in contrast to staff from Birch ward, who felt unhappy primarily because of shortages in substantive staffing and reliance on a temporary work force.

All staff we spoke with were familiar with the trust's whistle-blowing process and the role of the Speak Up Guardian. They identified local Speak Up Champions and told us the trust made Speak Up training available to them. Staff believed the trust valued staff speaking up and they felt able to raise concerns without fear of retribution.

The trust provided staff with support for their own physical and emotional health needs through a number of wellbeing and prevention schemes. This included the trust's Self-Help, Open-Up, Others, Teamwork, Help and Enjoy (SOOTHE) wellbeing offer to all staff. The SOOTHE offer had been nationally recognised by NHS England and NHS Employers as an example of best practice.

The trust recognised and celebrated staff success. The trust's website featured staff recognised for their contribution locally, regionally and nationally.

Governance

Our findings from the other key question demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

The trust had governance processes in place, but it was not clear they always worked effectively to ensure safety and quality across their acute wards and PICU. Governance meetings from both the Staffordshire and Stoke-On-Trent Care Group and the Shropshire, Telford Wrekin Care Group had frameworks of what must be included to ensure essential information, such as learning from incidents and complaints, was shared and discussed. Governance records showed the trust was sighted on many of the concerns identified by our inspection, including staff recruitment, the completion of mandatory training and easy access to trust electronic systems. However, it was not clear that implementation and oversight of actions to address concerns were sufficient and timely to demonstrate improvements to safety and quality at ward level.

Our inspection identified operational inconsistencies at site level and at ward level within the trust's acute mental health wards for working age adults and the PICU. This included the identification of risks, the management of risks, and the understanding and implementation of trust policy and procedural guidance. The trust identified work in progress to better align and ensure consistency of staff practice across the wards at both The Redwoods Centre and St George's Hospital. This included ensuring the understanding and implementation of trust policy and procedures by staff. For example, to manage environmental risks competently.

Our findings

The trust was reliant on temporary staff to meet ward staffing requirements, however governance processes failed to provide assurance temporary staff were always inducted to the ward they worked on and supported to deliver safe care and treatment. Practices to ensure bank or agency staff received a local induction did not always appear robust or well understood by all staff. Furthermore, it was not clear where completed local induction records were kept or how the Trust monitored completion of them. The trust did not routinely provide agency staff with access to electronic systems. This included policy and procedural guidance, actions or learning following incidents, and details of trust values to guide staff practice and conduct with patients. This undermined processes to ensure safety and quality in the service.

Management of risk, issues and performance

Ward level risk registers did not always demonstrate consistency in the risks identified or the actions in place to manage an identified risk.

The identification and recording of risks to ward level risk registers was not always consistent across the trust's acute wards for working age adults. Ward level risk registers at St George's Hospital identified mixed sex accommodation as a risk, while not all the ward level risk registers at The Redwoods Centre did. However, mixed sex accommodation breaches and sexual safety incidents occurred at both sites.

We also saw existing or planned actions identified to manage a similar risk were not co-ordinated across wards or sites. Individual risk registers for the acute wards at St George's Hospital shared common themes including staffing, mixed sex accommodation and patient access to contraband/risk items. However, although risks identified were similar across the site, the existing or planned actions to manage the risk at ward level were not. For example, actions in place to manage patient access to contraband/risk items differed between wards. Individual risk registers for the acute wards at The Redwoods Centre identified fewer risks but did include staffing and patient access to contraband/risk items. Again, the identified actions at ward level to manage those risks were different.

We saw long term high levels of vacancies across inpatient services at The Redwoods Centre and the admission of under 18 year olds to inpatient services specifically identified in the trust board risk register. Board papers were accessible to the public through the trust's website.

The trust had plans in place to manage emergencies. For example, adverse weather or infectious illnesses.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure ligature risk assessments identify all areas of potential risk and detail actions to reduce the harm from those risks within the acute mental health wards for working age adults and the PICU. (Regulation 12)
- The trust must ensure environmental assessments demonstrate suitable and sufficient fire safety assessment at The Redwoods Centre. (Regulation 12)
- The trust must ensure staff within the acute mental health wards for working age adults and the PICU safely manage items of potential risk as part of patients' personal property. (Regulation 12)
- The trust must review mixed sex accommodation arrangements within the acute mental health wards for working age adults with a view to reducing sexual safety incidents that occurred. (Regulation 12)
- The trust must ensure staff within the acute mental health wards for working age adults and PICU always assess patient's mental state at the point of taking leave and record these discussions and decisions in patients' clinical records.(Regulation 17)
- The trust must ensure agency staff working within the acute mental health wards for working age adults and the PICU have easy access to the trust's electronic systems. Including access to service user records, policy and procedural guidance and training resources. (Regulation 17)
- The trust must ensure that lessons learned post incidents are effective shared to all staff across the service, including agency staff. (Regulation 17)
- The trust must ensure staff working within the acute mental health wards for working age adults and the PICU complete and remain up to date with mandatory training requirements. (Regulation 18)
- The trust must ensure safeguarding children and young people training complies with national guidance. (Regulation 18)
- The trust must ensure and demonstrate bank and agency staff working within the acute mental health wards for working age adults and the PICU always receive an induction to the ward they work on. (Regulation 18)

Action the trust SHOULD take to improve:

- The trust should continue to actively seek and implement solutions to staff recruitment and retention challenges within the acute mental health wards for working age adults and the PICU. (Regulation 18)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a specialist advisor and an expert by experience. The inspection team was overseen by a Head of Hospital Inspection.

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 18 HSCA (RA) Regulations 2014 Staffing

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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