Requires Improvement

Sussex Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Meadowfield Hospital	RX277	Maple and Rowan wards	BN13 3EF
Oakland's Centre for Acute Care	RX26N	Oakland's ward	PO19 6GS
Mill View Hospital		Regency, Caburn and Pavilion wards	BN3 7HZ
Department of Psychiatry, Eastbourne general Hospital		Bodian, Heathfield and Amberley wards	BN21 2UD
Woodlands Conquest Hospital		Woodlands ward	TN37 7PT
Langley Green Hospital	RX2PO	Opal, Jade, Coral and Amber wards	RH11 7EJ

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Sussex Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Sussex Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Sussex Partnership NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 
Are Acute wards for adults of working age and psychiatric intensive care units safe?	**Requires Improvement** 
Are Acute wards for adults of working age and psychiatric intensive care units effective?	**Requires Improvement** 
Are Acute wards for adults of working age and psychiatric intensive care units caring?	**Good** 
Are Acute wards for adults of working age and psychiatric intensive care units responsive?	**Requires Improvement** 
Are Acute wards for adults of working age and psychiatric intensive care units well-led?	**Requires Improvement** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

Overall inpatient services were rated as requires improvement as care and treatment were not consistent across all wards. We found areas of excellent practice, for instance adherence to Department of Health (2010) requirements that 'Venous thromboembolism' (VTE) risk assessments take place for every patient. However, we found that wards did not always comply with the Department of Health gender separation requirement.

Whilst most wards were found to be clean and well maintained, there were infection control issues on one one ward.

We also found the quality of care planning and risk assessment variable and inconsistent.

People were moved around to manage bed shortages and often beds were not available close to their homes.

Across all wards, on each of the six hospital sites, patients in general, were genuinely happy with the care they received.

We saw that staff were kind, caring and built positive relationships with patients, their families and carers.

Summary of findings

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

Are services safe?

Requires Improvement

We rated safe as requires improvement because:

- On Oakland's ward we found patients' prescription only drugs were not held securely.
- On Maple ward patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation.
- Wards did not always comply with the Department of Health gender separation requirements. For example at Meadowfield hospital and Oaklands ward, female only lounges were locked. All three wards were mixed gender and although they attempted to separate the genders into different corridors, depending on the gender of the patients admitted, this was not always possible. Not all bedrooms were ensuite and on Oaklands ward female patients had to pass a male area to access toilet and bathroom facilities. On Heathfields ward at the Department of Psychiatry we were concerned that male patients were required to walk through female areas to access bathrooms. In addition, there was one assisted bathroom situated in the male area and this was used by female patients if needed.
- On Oakland's ward we found patients who were not detained were prevented from leaving the ward for 24 hours or longer.
- On Maple ward not all restraint incidents were reported.
- Risk assessments on Maple ward were generic in nature and were not person centred.
- On Oaklands ward a detained patient had been administered medication without appropriate authority for ten days.
- The soft furnishings on Maple ward were in poor condition which presented an infection control risk.

However, elsewhere we found :

- Safe and clean environments throughout the wards.
- Staffing levels were sufficient to meet patients' needs to a good standard.
- That there were good incident reporting systems in place, on most wards, and, there were strong feedback mechanisms in place, in order to learn lessons when things may have gone wrong.

Summary of findings

- Risk formulations were consistently strong and used a recognised methodology.
- There were good safeguarding practices.
- We found evidence of good medicines management.

Are services effective?

Requires Improvement

We rated effective as requires improvement because:

- At Meadowfield hospital and on Oaklands ward staff had not received mandatory training within the timescales set by the trust.
- The Meadowfield hospital and Oaklands ward staff had not received supervision, appraisals or undertaken reflective practice in line with the trust's policy. Many staff had not received any formal support in the past year.
- At Meadowfield hospital and on Oaklands ward the quality of assessment and care planning was variable. We found that care plan documentation did not always reflect the quality of care given and was not recovery focussed. On one ward the quality of assessment, care planning and review was poor.
- In Meadowfield hospital patients did not always have access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services, as the trust did not have a service level agreement with the local community NHS trust.
- On some wards staff had limited understanding of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). There was limited evidence of staff training in the MCA/ DoLS.

However, elsewhere we found:

- Clear evidence of best practice being used.
- The interaction between all members of the multi-disciplinary teams facilitated excellent communication and consideration of a holistic approach to patients and their care and treatment.
- All contributions from the multi-disciplinary teams' members were considered equally valuable.
- Creative input from faith advocates.
- Housing needs identified on admission.
- All patients had their needs assessed and a care plan implemented.

Summary of findings

- Patients' physical healthcare needs were met.
- The Mental Health Act was implemented effectively and appropriately.

Are services caring?

Good

We rated caring as good because;

- Across all wards, on each of the six hospital sites, patients in general, were genuinely happy with the care they received.
- We saw that staff were kind, caring and built positive relationships with patients, their families and carers.
- Friends, families and advocates were involved as appropriate and in accordance with the patients' wishes.
- On all wards we saw that staff involved patients in their care and support. Although this was not always documented, staff supported patients in making decisions when needed.
- Through observations and interviews with staff and patients we repeatedly and consistently saw and heard how kind, respectful and person centred the staff were.
- We did not see or hear any adverse interactions on any of the wards we inspected. Where we received adverse comments these were fed back to the ward managers and action was taken immediately to remedy any issues.

However, we did find:

- That on Maple ward, we heard staff refer to patients by their diagnosis and not their names, with the expectation they would be readmitted. This lacked respect and the ethos of hope and recovery.

Are services responsive to people's needs?

Requires Improvement

We rated responsive as requires improvement because;

- Patients were not always able to access care as close to home as possible. Bed shortages across the trust meant that patients from other areas were often accommodated in Maple, Rowan and Oaklands wards. Patients were often transferred several times before accessing care close to their home.
- Discharge in Maple, Rowan and Oaklands wards were often delayed because of lack of suitable accommodation to move on to. We saw little active engagement with stakeholders to resolve the issues or establish co-ordinated pathways of care.

Summary of findings

- On Maple ward the environment required refurbishment and redecoration.
- The ward payphones at Meadowfields and Oaklands wards were situated in communal areas of the wards which meant that patients could not make phone calls from these pay phones in private.
- At the Department of Psychiatry and Woodlands Conquest hospital there were high numbers of patients admitted from outside their local area.
- There was a lack of evidence on some wards at the Department of Psychiatry and Woodlands Conquest hospital of discharge planning.
- At the Department of Psychiatry and Woodlands Conquest hospital significant numbers of patients were considered to be delayed transfers of care due, mainly, to housing issues.

However, elsewhere we found:

- Meadowfield Hospital was open with an unrestricted access policy managed through therapeutic relationships.
- On Oakland's ward we saw that patients had the use of a multisensory room and gym.
- All patients had access to outside areas for therapeutic activities and fresh air.
- On Oaklands ward we saw patients actively involved in their discharge planning.
- All wards had quiet areas where patients could meet visitors including family rooms, gyms and spiritual rooms. Meadowfield Hospital and Langley Green had a café on site for patients' staff and visitors.
- At Mill View hospital the overarching bed management and associated processes were clear, well understood and implemented well.
- We found consistent evidence of comfortable environments which optimised privacy and dignity at Mill View hospital.
- At Mill View hospital the system for managing and responding to complaints was well embedded and learning from such events was routine.
- We found a rich and diverse selection of therapeutic activities available for patients at Mill View hospital.

Summary of findings

- At Langley Green hospital we saw there were bed pressures on the service, which included patients waiting to find suitable alternative accommodation, and, others waiting to return to the hospital. However, there was a process for managing and reviewing this, and it was not raised as an issue with us by patients or staff.
- All patients had their own rooms at Langley Green hospital, which were private and accessed by their own swipe card. There was access to water, hot drinks and snacks.
- There was a room that was accessible by a person in a wheelchair on each ward at Langley Green hospital.
- Patients and carers could make complaints to staff on all of the wards, and these were investigated and responded to. Reponses were friendly, and tailored to the individual.
- The crisis teams worked with the wards to prevent patients being admitted to the service where possible, and support patients discharge as soon as possible.

Are services well-led?

Requires Improvement

We rated well-led as requires improvement because:

- We found several areas of concern related to poor practice at Meadowfield hospital and the Oakland's centre for acute care. We found the majority of these concerns were concentrated on Maple and Oaklands wards. These two wards provided services for 33 beds out of a total of 246 acute and PICU beds for adults of working age. These beds were provided across 14 wards and from six hospital sites. We found, on the majority of the other wards, areas of good and also outstanding practice. Due to our concerns on Maple and Oaklands wards we were unable to rate this domain, proportionately, any higher than requiring improvement.
- We found the trust collected alot of data through auditing and mandatory data collection. We found there was little evidence at Meadowfield hospital and Oaklands ward that this information was fed back to the ward managers to enable them to improve practice.
- At Meadowfield hospital and on Oaklands ward, over the past year, staff supervision, appraisals and training had not been identified as a priority with resources allocated to enable staff to attend.

Summary of findings

- At Langley Green hospital the quality of the service was monitored and reviewed at a local level. However there were gaps within this, and some of the records were poor, such as the training records.
- Individual incidents and complaints were recorded, and reviewed at regular meeting within the service. However, there was limited evidence of a wider analysis of common themes arising from incidents and complaints at Langley Green hospital.
- At Langley Green hospital there was limited evidence of analysis of incidents and complaints that would identify themes or trends, and take action to address these and prevent them happening again.

However, elsewhere we found:

- Ward managers had sufficient authority, autonomy and administrative support to effectively manage their service.
- The trust's own governance arrangements had identified the majority of issues found at inspection and had action plans in place to address the issues.
- Although staff were not all aware of the trust's vision and strategy they all aspired to provide high quality care for the patients in their care.
- Staff felt able to raise concerns with their immediate line managers confident that action would be taken.
- The trust had responded to staff concerns about the 12 hour shift patterns and planned a phased implementation to a three shift pattern from May 2015.
- Staff knew who the service managers, for the organisation were, and were aware they had visited their service.
- Staff spoke highly of their individual teams and the support they got from their colleagues.
- The trust placed a high value on research and developing best practice, encouraging staff innovation.
- We found staff groups on all of the wards who were highly motivated, had a positive approach to their work and had an overall good morale without undue stress.

Summary of findings

- We found a particularly strong senior management team at Mill View hospital which included consultant psychiatrists and other senior representatives from the multi-disciplinary team who were fully involved in all aspects of the service.
- We found several examples of innovative practice.

Summary of findings

Background to the service

Services:

Meadowfield Hospital

Meadowfield Hospital has been inspected once since registration by the Care Quality Commission and last received a visit by a Mental Health Act reviewer in May 2014.

Maple Ward

17 bedded Adult Mental Health Inpatient Service

Rowan Ward

17 bedded Adult Mental Health Inpatient Service

Oaklands Centre for Acute Care

Oakland's Centre for Acute Care has not been inspected since registration by the Care Quality Commission and a monitoring visit was carried out by a Mental Health Act reviewer during this inspection.

Oaklands Ward

16 bedded Adult Mental Health Inpatient Service

Mill View Hospital

Regency Ward

20 bedded Adult Mental Health Inpatient Service

Caburn ward

20 bedded Adult Mental Health Inpatient Service

Pavilion Ward

10 bedded male Psychiatric Intensive Care Unit

Department of Psychiatry, Eastbourne General Hospital

Bodiam Ward

18 bedded male Adult Mental Health Inpatient Service

Heathfield ward

18 bedded mixed gender Adult Mental Health Inpatient Service

Amberley Ward

18 bedded female Adult Mental Health inpatient Service

Woodlands Conquest Hospital

Woodlands Ward

23 bedded mixed gender Adult mental health Inpatient Service

Langley Green Hospital

Amber Ward

12 bedded mixed gender Psychiatric Intensive Care Unit

Coral Ward

19 bedded mixed gender Adult Mental Health Inpatient Service (7 beds for Sussex patients, 12 beds for East Surrey patients)

Jade Ward

19 bedded mixed gender Adult Mental Health Inpatient Service

Opal Ward

19 bedded mixed gender Mental Health Inpatient Service (11 beds for older adults, 8 beds for working age adults)

CQC has inspected Langley Green Hosptial on several occasions. At the time of our last inspection in October 2014, Langley Green Hospital was not meeting the essential stadards related to the care and welfare of patients (Regulation 9). The hospital had also been non-compliant following our previous inspection in February 2014, where we found that Langley Green Hospital was not meeting the essential standards related to respecting and involving patients (Regulation 17), the care and welfare of patients (Regulation 9), safeguarding patients from abuse (Regulation 11), management of medicines (Regulation 13), staffing (Regulation 22), assessing and monitoring the quality of service provision (Regulation 10), and records (Regulation 20). These compliance actions were inspected as part of the comprehensive review and the requirements had been met.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliott- Care Quality Commission

Team Leader: Natasha Sloman- Care Quality Commission

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of 23 people: 2 experts by experience, 4 inspectors, 4 Mental Health Act reviewers, 7 nurses, a pharmacist, 2 psychiatrists and 3 others. The team divided into six smaller teams and visited each of the six locations.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about wards for adults of working age and psychiatric intensive care units (Acute wards or PICU) and asked other organisations to share what they knew. We carried out an announced visit to each of the wards over six locations from 12/01/2015 to 16/01/2015. During the visit to each location we held focus groups with a range of staff who worked within the service, such as nurses, doctors, social workers and therapists. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

During the inspection visit, the inspection team:

- Visited all of the 14 wards at the six hospital sites and looked at the quality of the ward environments and observed how staff were caring for patients.
- Spoke with 79 patients who were using the service.
- Spoke with the managers or acting managers for each of the wards.
- Interviewed the divisional director with responsibility for these services.
- Attended and observed a variety of hand-over meetings and multi-disciplinary meetings.
- Spoke with eight relatives.
- Spoke with 78 staff members; including doctors, nurses, health care assistants, STR workers, occupational therapists, psychologists, art therapists and physiotherapists.
- Interviewed the matron, general manager and service director with responsibility for these services.
- Held a focus group for six consultant psychiatrists.

We also:

- Looked at 70 treatment records of patients including patients detained under the Mental Health Act.
- Carried out a specific check of the medication management on some of the wards.
- Looked at a range of policies, procedures and other documents relating to the running of the wards.

Summary of findings

What people who use the provider's services say

We spoke with patients and their relatives. Most were positive about their experience of care on the acute wards and psychiatric intensive care units. They told us that they found staff to be very caring and supportive, and most people were involved in decisions about their care.

Good practice

Meadowfield hospital and Oaklands ward:

- We found the occupational therapists were committed to providing high quality interventions and were always looking to implement new therapeutic treatments. For example the occupational therapists in Meadowfield hospital were working with a new form of music therapy which they reported as being very popular with patients.

Mill View hospital:

- Evidence seen of adherence to Department of Health (2010) requirements that 'Venous thromboembolism' (VTE) risk assessments take place for every patient. Adherence to The National Institute for Clinical Excellence (2010) recommendations on VTE risk assessments.
- Evidence seen that the malnutrition Universal Screening Tool (MUST) had been carried out for all patients and associated care plans developed where appropriate.
- The modified early warning system (MEWS) to help monitor a patient's physical health care needs was fully implemented for all patients.
- Reduction in use of seclusion from 2011-2014. Department of Health appointed Pavilion ward positive and pro-active champions.
- Pavilion PICU development program for all new staff.
- Experience-based co-design project at Mill View hospital using patients to direct environmental design of ward areas and quiet areas.
- Pavilion ward had been accredited and was a member of the National Association of Psychiatric Intensive Care units (NAPICU) as well as having obtained the Royal College of Psychiatry accreditation for inpatient mental health services (AIMS).
- Pavilion focus groups with patients to inform the available activity schedules.
- Pavilion ward student nurse placement initiate shortlisted for the Nursing Times student placement of the month award.
- Occupational therapy assessment and outcome measures were in place for all patients.
- Brighton and Hove recovery college prospectus was available to all patients.
- Mill View art project exhibition was advertised and all patients encouraged either participating in or enjoying the artwork on show.
- Appetite for innovation.
- IMHAS visibility and availability on a daily basis.
- Recovery approach.
- STAR wards initiative implemented throughout.
- Safe wards initiative implemented throughout.
- Multi-disciplinary working and integration.
- Culture of holistic approach.
- Rolling recruitment drive incorporating full assessment centre initiative with involvement from patients.

Langley green:

- Amber ward had been accredited and was a member of the National Association of Psychiatric Intensive Care units (NAPICU).

Summary of findings

- Rolling recruitment drive incorporating full assessment centre initiative with involvement from patients.
- Positive and safe champions.
- Access to recovery college.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Medicine management was not always conducted in accordance with the trust's policies or best practice guidance. For example on Oaklands ward, a detained patient had been administered medication without appropriate authority for ten days. On Oaklands ward we found patients' prescription only drugs were not held securely. On Maple ward patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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- At Meadowfield hospital and Oaklands ward staff had not received mandatory training within the timescales set by the trust. At Meadowfield hospital and Oaklands ward staff had not received supervision, appraisals or undertaken reflective practice in line with the trust's policy. Many staff had not received any formal support in the past year. This was in breach of Regulation 23(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- On Oaklands ward we found patients, who were not detained, were prevented from leaving the ward for 24 hours or longer. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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- At Langley Green hospital the service must improve the recording and analysis of incidents and complaints, and how lessons are learnt from this. This was in breach of Regulation 10 (1)(a)(2)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Wards did not always comply with the Department of Health gender separation requirements. For example at Meadowfield hospital and Oaklands ward, female only lounges were locked. All three wards were mixed gender and although they attempted to separate the genders into different corridors, depending on the gender of the patients admitted, this was not always possible. Not all bedrooms were ensuite and on Oaklands ward female patients had to pass a male area to access toilet and bathroom facilities. On Heathfields ward at the Department of Psychiatry we were concerned that male patients were required to walk through female areas to access bathrooms. In addition, there was one assisted bathroom situated in the male area and this was used by female patients if needed. This was in breach of Regulation 17(1)(a)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action the provider SHOULD take to improve:

Meadowfield hospital and Oaklands ward:

- The trust should review it's wards to ensure they comply with the Department of Health gender separation requirements. We found female lounge areas locked and on Oaklands ward female patients having to walk through areas occupied by male patients in order to access toilets and bathrooms.
- Ensure, on Maple ward that all restraint incidents were reported.

Summary of findings

- Review current systems in place for sharing learning, as staff told us that they did not always receive timely feedback.
- Review risk assessments on Maple ward as they were generic in nature and were not person centred.
- Review restraint procedure,s as when patients were restrained in their rooms, this was not considered by the wards to be a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion Policy.
- Replace the soft furnishings on Maple ward which were in poor condition and presented an infection control risk.
- Review the quality of assessment and care planning, as we found this to be variable. We found that care plan documentation did not always reflect the quality of care given and was not recovery focussed. On one ward the quality of assessment, care planning and review was poor.
- At Meadowfield hospital, review patients' access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services as the trust did not have a service level agreement with the local community NHS trust.
- Ensure patients can access care as close to home as possible. Bed shortages across the trust meant that patients from other areas were often accommodated in Maple, Rowan and Oaklands wards. Patients were often transferred several times before accessing care close to their home.
- Review discharge planning as discharge was often delayed because of lack of suitable accommodation. We saw little active engagement with stakeholders to resolve the issues or establish co-ordinated pathways of care.
- Expediate refurbishment and redecoration of Maple ward.
- Review the provision of the ward payphones which were situated in communal areas of the wards which meant that patients could not make phone calls from these pay phones in private.
- Ensure staff receive timely feedback from complaints. There was little analysis of themes or trends at ward level.
- Ensure that information from a variety of data collection processes is fed back to the ward managers to enable them to improve practice.
- Ensure staff supervision, appraisals and training is prioritised and resources allocated to enable staff to attend.
- Support staff and encourage them to adopt best practice. Where staff had been in post for some time we found a lack of contemporary practice which was exacerbated by a lack of training.

Action the provider SHOULD take to improve:

Mill View hospital:

- Fire evacuation timetable for 2015 to be planned and executed.
- Training to be implemented for all wards on slips, trips and falls.
- Mandatory training should be compliant to 100% across all wards.
- Care record documentation to reflect a holistic, person centred, recovery approach highlighting strengths of patients.

Action the provider SHOULD take to improve:

Langley Green:

- The trust should review provision of gender segregated facilities on the wards.
- The trust should resolve its staff shortages.
- The trust and the local service must improve the effectiveness of the links between the corporate and local governance processes.
- The trust should review staff understanding and monitoring of the Modified Early Warning Score (MEWS) records, where routine physical observations of patients are recorded (such as blood pressure and pulse).
- The trust should improve the accuracy of the staff training records, so that they reflect the training staff have completed.

Summary of findings

- The trust should review access to psychology within the service.
- The trust should ensure that its entire staff has adequate knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Care plans should be individualised and tailored to the needs of each patient.
- The trust should ensure that patients admitted out of the area, are returned to the unit as quickly as possible, and that patients no longer requiring admission are discharged to a suitable placement as soon as possible.

Sussex Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Maple and Rowan wards	Meadowfield Hospital
Oakland's ward	Oakland's Centre for Acute Care
Regency, Caburn and Pavilion wards	Mill View Hospital
Bodian, Heathfield and Amberley wards	Department of Psychiatry, Eastbourne General Hospital
Woodlands ward	Woodlands Conquest Hospital
Jade, Coral, Opal and Amber wards	Langley Green Hospital

Mental Health Act responsibilities

- We found that on Maple, Rowan and Oaklands wards that the legal paperwork was generally in good order. The Approved Mental Health Professional reports were available on the relevant patients' notes on Rowan ward.
- In one case on Oakland's ward and in all relevant cases on Maple ward, there were no AMHP reports on the patient's notes.
- There was evidence that patients had had their rights discussed with them on admission and regularly afterwards on all wards, except Maple ward.
- Section 17 leave forms were generally in good order. However in one case on Maple ward the form was poorly completed with unclear conditions and the length of the leave not recorded. In one case on Oaklands ward who the patient was to be accompanied by, was not recorded. In all cases on Oakland's ward there was

evidence that copies of the leave form had been given to patients and relatives as required. On Maple ward there was no evidence that patients and relatives had been given copies of their leave form.

- We checked all the files of the detained patients at Mill View hospital on both the acute wards and PICU to ensure that appropriate documentation was in place to reflect what was required in the Mental Health Act and Code of Practice, and, in most cases this was correct. The trust could demonstrate that there is a systemic process in place to ensure that the operation of the Mental Health Act meets legal requirements. Weekly ward audits of Mental Health Act 1983 paperwork had been introduced and this enabled staff to ensure that the requirements of the act were being met.
- Good conditions of Section 17 leave were being recorded and reviews of risk carried out prior to leave. Capacity and consent was being assessed and recorded on admission and within the first three months prior to the statutory requirement to do this which was felt to be good practice and in line with the Mental Health Act 1983, accompanying Code of Practice. Section 132 rights were found in most cases being given and recorded in line with the trust policy.
- Care plans were not designed to be service user led and contained language and "jargon" that patients may not understand, such as abbreviations (without explanation) and medical terminology. The care plans did not show involvement of or include the strengths of the patient.
- There was no evidence found on care plans or within the notes regarding statements being made by detained patients with regard to their preferences for what they would or would not like to happen. This included legally binding advance decisions to refuse treatment and "wishes expressed in advance" in line with the Code of Practice – Chapter 17.
- Good signage was observed throughout all of the wards at Mill View hospital, offering informative information for patients and carers including information regarding Independent Mental Health Advocacy Services (IMHAS). This was seen as being readily available for patients and IMHAS visited the wards on a daily basis which was noted as good practice. Notices were in place on exit doors for informal patients who wished to leave the ward.
- At the Department of Psychiatry and Woodlands Conquest hospital staff demonstrated a good understanding of their responsibilities in relation to the Mental Health Act 1983 and the Code of Practice. Patients told us staff explained their rights to them on a regular basis and we saw there were records to support this. There were regular audits carried out to monitor compliance with the Mental Health Act 1983. Information about the Independent Mental Health Advocacy Service was displayed, although one of the notices did not have any contact details for the service. Patients we spoke with confirmed they were able to contact an advocate if this was needed. All paperwork viewed was appropriate and in good order.
- At Langley Green hospital, Mental Health Act documentation was in good order. There was evidence that patient's capacity to consent to treatment was assessed on admission and regularly thereafter. There was evidence that patients were regularly informed of their rights as required by section 132 of the MHA.
- Training logs indicated that not all staff had received up to date MHA training at Langley Green hospital.
- Independent Mental Health Advocates (IMHA) were involved with patients and there was information on the ward about this service. Some staff did not have a clear understanding of the role of the IMHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' capacity to consent to treatment was assessed on admission and regularly reviewed and the reasons for the decisions were generally well documented.
- The requirements of Part IV of the Act with regard to medical treatment were generally complied with except for one case on Oakland's ward where in the case of a patient whose community treatment order had been revoked; there was no appropriate authority to administer medication despite it being 10 days since the revocation.

Detailed findings

- At Langley Green hospital training logs indicated that many staff had not received Mental Capacity Act (MCA) training. A number of staff we spoke with did not have a clear understanding about the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). We were told that advice on the Mental Capacity Act was available from the Mental Health Act administration office.
- In all other wards staff had a clear understanding about the MCA and DoLS.

Requires improvement

Are services safe?

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

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

Summary of findings

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

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

Our findings

Acute Wards

Safe and clean ward environment

- The ward layouts enabled staff to observe most parts of the ward and risk mitigation plans were in place where this was not easily possible.
- Wards had ligature risk assessments carried out. Specific action to be taken, to mitigate the risks identified, were detailed, and, a named lead to take forward the action was also identified.
- We found there had not been any incidents involving ligatures on the wards we visited at Meadowfield hospital or Oaklands ward, however, a patient had obtained a pair of ligature cutters from the ward clinic room. Following this incident, action had been taken to remove cutters to a more secure location further within all treatment rooms.
- Wards did not always comply with the Department of Health gender separation requirements. For example at Meadowfield hospital and Oaklands ward, female only lounges were locked. All three wards were mixed gender and although they attempted to separate the genders into different corridors, depending on the gender of the patients admitted, this was not always possible. Not all bedrooms were ensuite and on Oaklands ward female patients had to pass a male area to access toilet and bathroom facilities. On Heathfields ward at the Department of Psychiatry we were concerned that male patients were required to walk through female areas to access bathrooms. In addition, there was one assisted bathroom situated in the male area and this was used by female patients if needed.
- At Langley Green hospital all patient bedrooms were single and had an ensuite shower and toilet. Staff on all four wards told us that they had male and female corridors. However, we saw that on Coral, Jade and partially on Amber wards these were not consistently maintained, and men and women's rooms were allocated throughout the ward. This was not ideal, but it did not contravene Department of Health guidance on single gender accommodation. Staff told us that if a woman needed to be on a female-only ward, there was one available within the trust in Brighton.
- At Langley green hospital patients had absconded from the hospital on several occasions, following which serious incidents had occurred. The service had plans to replace the perimeter fence to prevent patients from absconding over the fence, and to make the grounds more secure.
- There was a seclusion room in the psychiatric intensive care units (PICU) at both Langley Green and Mill view hospitals. Both had appropriate protocols for use, clear observation, toilet facilities and a clock in accordance with the Mental Health Act (MHA) code of practice.
- We asked patients if they felt safe in all of the hospital wards and sites, and they all said they did.
- Emergency equipment was stored in all of the wards in well equipped clinical rooms. An automated external defibrillator and anaphylaxis pack were in place. All emergency equipment was checked weekly to ensure it was fit for purpose and could be used effectively in an emergency.
- We did note at Meadowfield hospital and Oaklands ward that few staff had received recent mandatory life support training, for example, one staff member last had life support training in 2012. Staff were aware of the protocol for summoning emergency assistance and told us the protocol was to call 999 and await the emergency services. This meant that patients were at risk through staff not being up to date with basic life support training.

Requires improvement

Are services safe?

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- Most wards were well maintained and clean throughout, with the exception of Maple ward at Meadowfield hospital. Furniture, fixtures and fittings were provided to a good standard. Staff conducted regular audits of infection control and prevention, and, staff hand hygiene to ensure that patients, visitors and staff were protected against the risks of infection.
- On Maple ward we found the soft furnishings were torn, split and generally in poor repair. This presented an infection control risk.
- There were suitable arrangements in place for the management of waste which included the segregation, storage, labelling, handling and disposal of waste.
- We saw that cleaning checklists were maintained and regular infection control and prevention audits undertaken. There were appropriate facilities available for the safe disposal of sharp objects such as used needles and syringes. These were labelled with the ward and date and not over-filled.
- Alarms were available in each room on most of the wards, on all of the sites and all staff carried alarms. We were told by staff that alarms are responded to in a timely manner. We noted on Bodian ward that the alarms for patients to use to summon assistance had their pull buttons removed. This made it difficult for patients to then use the alarms in the event of them needing assistance. We noted they were not consistently removed throughout the ward however.
- We saw evidence that wards at Mill View hospital participated in the monthly health and safety meeting, membership across all acute and urgent care teams, chaired by the service director.
- We saw evidence that wards were represented at the Mill View site safety meeting held regularly to ensure optimum safety of the entire hospital site.

Safe staffing

- The overall percentage of staff vacancies during 2014 was 9.4%. However there were areas with a vacancy rate of 25% or more. On the wards we visited we found there were some vacancies however these were being actively recruited to.
- The trust's 12 hour shift pattern had been in place for over a year, with the exception of Mill View hospital. Managers told us this had reduced the staffing costs but had resulted in little available time allocated for staff to attend training, development or supervision. We were told that record keeping, care planning and incident reporting had also suffered as staff had little allocated time available for administrative work. The managers we spoke with told us although they were under budget with staffing costs, the trust had agreed to revert to the original three shift pattern due to the concerns raised by staff. Managers told us that the trust was recruiting additional staff to cover vacancies and the additional staffing requirements of implementing the three shift system. In many cases the staff had been recruited and were awaiting a start date.
- The service at Langley Green hospital used a staffing ladder/tool to calculate the number of staff required each shift. The service monitored its use of staff, and these showed that the majority of shifts were above the minimum level. For example many shifts were at 200-300% above the minimum. This was attributed to a high use of additional staff for enhanced observations, so it did not account for whether there were sufficient numbers of staff to meet the needs of patients.
- Langley Green hospital had a number of vacancies, particularly of band 5 staff nurses. The service had a strategy to address this, and we saw that this was routinely discussed and taken forward in leadership meetings. The strategy included an ongoing advertising and interview programme, which aimed to make the recruitment process easier. Other strategies included considering overseas recruitment, and building on flexible working by employing more bank nurses.
- Langley Green hospital regularly used bank and agency staff. The service was building up its team of bank staff, who were used on an 'as necessary' basis, but were directly employed by the trust. The service monitored its use of bank and agency staff. For example, during two weeks in December 2014 the use of bank and agency nurses on Coral ward was 63%, although this had reduced by January. Current bank and agency use on Opal ward for the last three months was above 50%.
- Whilst acknowledging extremely busy shifts most staff we spoke to said there were sufficient staff to delivery care to a good standard.
- For example at Mill View hospital we were told that band six nurses and more senior nursing staff participated in a rota to respond to the place of safety activity. We saw

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that due to time spent on this rota, the staffing ratio had been increased by one band six nursing post each day on every ward to provide clinical expertise on a daily basis. This had received positive feedback from staff.

- We saw on Oakland's ward there were two nursing vacancies needed to be filled in order to implement the three shift system.
- We saw on Amberley ward at the Department of Psychiatry there was only one vacancy for a qualified nurse.
- We noted on Maple ward that since an additional member of staff had been recruited for the S136 Suite this had taken a lot of pressure off the staff. They told us that prior to the nurse being appointed there were times when they felt that the ward was not safe as a nurse was taken from the ward to look after the patient in the place of safety.
- At Mill View hospital a new recruitment process had been introduced over the last year to ensure vacancy levels decreased and to reduce the recruiting time line. We saw that the average recruitment period had reduced by four weeks. We saw that Regency ward had no vacant qualified nurse posts and less than three vacancies for non-qualified staff. Caburn ward had five newly qualified nurses recently started working on the ward and was fully established. Temporary staffing usage on both wards was low.
- We reviewed the staffing rotas on all of the wards and found that the number of staff on shift usually matched the agreed establishment. Agency and bank nurses were used where there was a shortfall.
- When temporary staff were used we saw that the trust's own bank staff were called upon and agency staff who preferably knew the ward were used at short notice if required.
- We were told by the ward managers that senior managers were flexible and responded well if the needs of the patients' needs increased and additional staff were required.
- We noted sickness absence rates for both Regency and Caburn wards was below 3% and the acute and urgent care division had a sickness rate of 5.17%.
- The staff told us it was not always possible to escort patients on leave at the particular time they required. We were told they kept cancellations of escorted leave to an absolute minimum.
- The majority of patients were offered and received a one-to-one session with a member of staff every day.
- Staff that had been trained in the use of physical interventions were identified on the rota to ensure there were sufficient staff available if required to assist.
- We saw evidence that the acute wards had access to a wider multi-disciplinary team which included occupational therapists, psychologists, art therapists, a physiotherapist and a pharmacist.
- Medical staff told us that there were adequate doctors available over a 24 hour period, seven days each week who were available to respond quickly on the ward in an emergency.

Assessing and managing risk to patients and staff

- The information provided by the trust indicated that during 2013 to 2014 the number of patients involved in a serious incident within three days of being admitted to an acute hospital bed was identified as a risk. We found that staff undertook a risk assessment of every patient on admission and this was updated regularly. On admission vulnerable patients were placed on ehanced observations until no longer assessed as a risk.
- We sampled, for example, at Mill view hospital 10 care records on Regency and Caburn wards including all records of patients detained under the Mental Health Act, and, found a comprehensive risk assessment in place for all patients on admission. We found the risk formulations were good and used a recognised risk assessment tool (The five Ps) which all staff we spoke to had been trained to use. We saw evidence that risk assessments were reviewed as part of the multi-disciplinary care review process as detailed in the acute inpatient service operational policy.
- We looked at the standards for acute care which detailed the level of engagement and assessment patients could expect to receive when admitted into hospital and for the first seven days.
- We noted at Meadowfield hospital and on oaklands ward that the quality of risk assessments varied

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between wards. Some were holistic, personalised and clearly documented the risks to patients, together with the actions needed to control the risks. Others were generic in nature and lacked evidence of thorough reviews or changes to the assessments. For example on Rowan ward the care plans documented the current and historical risk with a clear action plan in place to manage the issues. The care plans documented the patients' views on the plan to manage the risk and their views were taken into consideration.

- Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was safely managed. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of patients previous risk history as well as their current mental state.
- We found that any blanket restrictions, such as contraband items and locked doors to access and exit the ward doors where justified and clear notices were in place for patients explaining why these restrictions were being used.
- Informal patients were advised through signage that they were free to leave at will and this information was also detailed in the ward information leaflets. We raised one issue with managers at Langley green hospital where a staff member had thought informal patients could be detained under the Mental Health Act if they attempted to leave the ward. This was addressed promptly. We also raised the concerns we noted on Oaklands ward of informal patients having to wait on the ward for 24 hours before being permitted to leave the ward.
- The trust had policies and procedures in place for the observation and searching of patients to ensure risks of self-harm were minimised. The policies were all available on the trust's intranet and the staff we spoke with were aware of how to access them.
- Between April to September 2014 the trust reported 384 incidents where restraint was used within 42 different areas across 19 hospital sites. 15% concerned individuals who were restrained in the prone position of which 31 resulted in rapid tranquilisation. At Meadowfield Hospital and Oaklands ward there were less than 20 incidents of restraint in the same time period.
- On Rowan ward we observed an acutely unwell patient being restrained and assisted to their room to de-escalate safely. The patient was supported with gender appropriate staff using the correct hold with the minimal amount of restrictive practice used.
- Patients on Bodiam ward told us they had not been restrained whilst on the ward but had witnessed restraint and felt it had been managed, "Very professionally" by staff. There were no seclusion facilities at the department of Psychiatry and any patients who needed more intensive care were transferred out to the local PICU.
- The trust had a policy regarding the use of rapid tranquilisation which adhered to National Institute for Clinical Excellence (NICE) guidelines.
- Meadowfield Hospital and Oakland ward did not have separate seclusion rooms and did not document or report as seclusion when patients were restrained in their own room. We found that acutely disturbed patients were on occasion restrained in their room until their behaviour was assessed as no longer a risk to themselves or others. This was considered by the wards to be restraint rather than a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion policy.
- The trust had in place a safeguarding policy which had been reviewed and updated in September 2013. The policy addressed key lines of accountability, the procedures for staff to follow, details of the mandatory training and how compliance with the policy would be monitored. The policy included key contact numbers and reflected the pan Sussex multi-agency safeguarding policies. We also saw safeguarding flow charts and safeguarding procedure reminders on staff notice boards.
- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe

Requires improvement

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what constitutes abuse and were confident in how to escalate any concerns they had. Most staff had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy.

- We observed staff considering safeguarding issues when discussing patients care and treatment during multidisciplinary meetings.
- Managers and staff did not always receive timely feedback about safeguarding incidents which meant that opportunities for learning were restricted.
- Although in general, at Meadowfield hospital and on Oaklands ward the management of medicines was safe, we found instances where drugs were not stored safely, recorded or administered appropriately. We saw that the pharmacists and pharmacy technicians visited the wards daily and regularly conducted drug audits to monitor drug usage and compliance with medication policies. For example we saw that the pharmacist in Meadowfield Hospital conducted an audit of missed doses and displayed the findings in the clinic room.
- We reviewed the medication charts on Maple ward and found that a number of them were incomplete with missing dates, incorrect spelling of the drugs prescribed.
- On Oaklands ward we found that patients' prescription only medicines were held in a domestic style cupboard that was not easy to secure. The cupboard was open when we the arrived on the ward and although the manager attempted to lock the cupboard, it remained unlocked. There were no records of the medicines kept in the cupboard. Several packets of medicines were out of their containers and it could not be established which patient the medicines belonged to. This was not a safe and secure means of storing patients' medication.
- We saw at Mill View hospital that patients received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations.
- Patients were provided with information about their medicines. We observed this in a discussion in a multi-disciplinary care review. Staff discussed changes to the patients' medicines with them and provided leaflets with more information.
- Our pharmacist inspector checked the management of medicines on both Regency and Caburn wards at Mill View hospital and found that appropriate arrangements were in place.
- For any patients wanting to see children from their family we found that processes and protocols had been put in place to accommodate this. Each request was risk assessed to ensure a visit was in the child's best interest. A separate family room away from the wards was available at all sites.

Track record on safety

- At Mill View hospital, recent incidents reported from Regency ward included a fire started by a patient in his room, a patient assaulted a visiting relative and a patient suffered a broken arm whilst arm wrestling with another patient. A death of a patient on Caburn ward was reported in February 2014 as the most recent serious untoward incident.
- At Langley Green hospital an independent report was commissioned by NHS England, and published in July 2014, into a murder of one patient by another, both from Langley Green hospital. The report found that the trust had made improvements since the incident. However, a CQC inspection of care in October 2014 found that a number of issues remained outstanding. This inspection has found that many of these have now been addressed.

Reporting incidents and learning from when things go wrong

- The trust had policies and procedures in place to manage incidents which were reported on an electronic system which recorded details of the incident and the action taken.
- We found a variety of differing standards across the acute wards regarding incident reporting.
- Most staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. All incidents were reviewed by the ward managers and forwarded to the general managers. All incidents were electronically forwarded to the patient safety team (governance). The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these.

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- We were told by the ward managers that lessons learnt from incidents were shared at the regular ward managers meetings facilitated by the matron and general manager for Mill View Hospital. We found the systems and processes regarding incidents, particularly strong and robust at Mill Vew hospital.
- We looked at the serious incident briefing sent monthly to the Mill View hospital wards, Regency and Caburn, with details of all incidents and learning identified with associated action plans.
- In Meadowfield Hospital and Oaklands ward we found that staff were aware of the trust's policies for reporting risk and knew how to access the system. However we found that not every incident of restraint was reported appropriately according to the trust's policy.
- Managers at Meadowfield hospital and Oaklands ward told us that they couldn't be assured that every incident was reported as different staff had different thresholds of what should be reported. They told us that it may be an issue of not enough time to report appropriately and felt that a return to the three shift pattern would improve the time that staff got to undertake tasks such as reporting. They told us they were confident staff would report the 'Serious Incidents'. However on Rowan ward the ward manager identified that an incident form had not been completed for an incident that occurred the previous evening.
- On Maple ward staff told us that they did not have enough time to always report every incident. For example they told us that if no one was injured restraint incidents may not be recorded. They gave an example where a member of staff had a cup of coffee thrown over them which was not reported. They told us they would always report 'serious' incidents such as assaults and medication errors.
- Some managers told us that although they signed off each incident form they did not keep a record of how many in order to identify trends or themes. They told us that if there was a significant increase in the number of incidents such as restraint they would investigate. However without specific records being kept there was a risk that any changes might not be identified until it was picked up by the governance department several months away.
- Feedback was variable with managers and staff not always receiving timely feedback following incident investigation. Managers told us that they were responsible for ensuring that learning was fed back following an incident investigation. They told us that staff would usually receive feedback during supervision. However we noted that few staff had received supervision in the past year in some hospital sites.
- The formal feedback staff usually received was through the trust's quarterly 'Report and Learn' Bulletin. This contained key learning points for staff and sharing of best practice. Although this was a useful tool for disseminating information it did not provide staff with timely feedback following the reporting of any incident, safeguarding or complaint.
- Managers received a monthly report of the number of incidents but this did not identify trends or themes. We were told that the governance department was responsible for analysing the data and would feed back if there was an issue or in the quarterly governance report which provided an overview of the trust.
- We found at Meadowfield and Oaklands ward that staff rarely met to discuss any feedback. When it occurred feedback happened through informal handovers or may have occurred through the trust's bulletins which came out some time after the original incident. Feedback when it happened was not planned or part of the governance cycle.
- On Bodiam ward at the Department of Psychiatry, staff told us following a serious incident, there was an initial meeting for the staff involved to discuss the incident and make any initial analysis of the incident, and, put in place any support or changes to practice that are needed. After a short period of time, staff were invited to participate in a more detailed de-briefing session. Staff told us that changes were made following incidents. For example, we were shown a form that was completed prior to a patient going on leave to maximise communication and we saw this was routinely used.
- At Langley Green hospital, we looked at a sample of electronic incident forms, and staff and managers were familiar with the incidents, and could describe the action that had been taken as a result. Actions were also recorded on the electronic forms, which were submitted to a central office for review. An annual report of lessons learned from incidents that had occurred in the hospital

Requires improvement

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had been produced. However, we could not see how this information was fed back to the service, and there was no analysis of the incidents that identified recurring themes or trends, so that these could be addressed. There was a trust-wide bulletin which provided which provided some information about incidents across the trust.

- Staff debriefing meetings occurred after serious incidents. During our inspection, there was a staff debrief on Coral ward following a recent death on the unit. Staff told us they often did not receive any feedback following incidents. However, issues were discussed in staff meetings and individual supervision sessions.
- "Report and learn" bulletins were sent to staff and gave information about some of the complaints that had been received across the trust. This was ward or service specific and appeared sometime after the event. Significant issues which included incidents were discussed in team meetings. However, it was not clear how the service ensured that learning from incidents was shared with all staff, and effective changes made.

Psychiatrict intensive care unit (PICU)

Safe and clean ward environment:

- Pavilion ward was a psychiatric intensive care unit (PICU) located within Mill View hospital. The ward had 10 single bedrooms with en suite toilet and hand basin facilities. The ward was a male only unit. On the day of our visit there were ten patients, all were detained under the Mental Health Act (1983).The ward layout on Pavilion enabled staff to observe all parts of the ward.
- The ward was bright, clean, comfortably and well-furnished and decorated to a high standard. There was an open plan lounge, plus a separate quiet TV lounge with dimmed and calming lighting. On the day of our visit the kitchen and dining area were being refurbished and were not able to be used. The ward had adapted the therapy room to act as a temporary dining room whilst this work was being undertaken. All bed rooms had toilet and washing facilities and there were adequate shower rooms and a bathroom close by. A large nursing station was located in the centre of the ward which gave staff good access to patients without being intrusive. There was a large secure garden area which patients could access freely throughout the day.
- Pavilion ward also had an extra care de-escalation room, known as the calm room, a seclusion room and access to the section 136 assessment suite which were all in good condition with good facilities available for patient care. The seclusion room had en-suite toilet and shower facilities and a clock. The room had a full height window panel and a skylight allowing natural light into the room as well as providing a view onto a green outside area. Staff could observe patients in seclusion through the use of CCTV and two way audio equipment.
- Emergency equipment was stored in a large well equipped clinical room. An automated external defibrillator and anaphylaxis pack were in place. All emergency equipment was checked weekly to ensure it was fit for purpose and could be used effectively in an emergency.
- Staff conducted regular audits of infection control and prevention, and staff hand hygiene to ensure that patients, visitors and staff were protected against the risks of infection.
- Staff carried out a range of environmental and health and safety audits and risk assessments, including checks on any ligature points and standards of cleanliness.
- Alarms were available in each room on the ward and all staff carried alarms. We were told by staff that alarms are responded to immediately.
- We saw evidence that Pavilion ward participated in the monthly health and safety meeting, membership across all acute and urgent care teams, chaired by the service director.
- We saw evidence that Pavilion ward was represented at the Mill View site safety meeting held regularly to ensure optimum safety of the entire hospital site.

Safe staffing

- Whilst acknowledging how busy the shifts on Pavilion ward were, all staff we spoke to said there were sufficient staff to deliver care to a good standard. We were told that the ward was fully established with substantive staff. We were told that the nurse staffing ratio was less than that recommended by the National Association for Psychiatric Intensive Care Units (NAPICU)
- A new recruitment process had been introduced over the last year to ensure vacancy levels decreased and to reduce the recruiting time line. We saw that the average recruitment period had reduced by four weeks.

Requires improvement

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- When temporary staff were used we saw that the trust's own bank staff were called upon and agency staff who preferably knew the ward were used at short notice if required.
- We were told by the ward manager that senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required.
- We noted that the sickness absence rates for Pavilion ward was 8% and the acute and urgent care division had a sickness rate of 5.17%. We were told a number of substantive staff were on long term sickness absence and that these cases were being actively managed.
- The staff told us it was always possible to escort patients on leave at the particular time they required. We were told they kept cancellations of escorted leave to an absolute minimum.
- All patients were offered and received a one-to-one session with a member of staff every day.
- Staff that had been trained in the use of physical interventions were identified on the rota to ensure there were sufficient staff available if required to assist.
- On the day of our visit there were five staff on duty, including a ward manager, two qualified nurses together with three nursing assistants. Also present on the ward were an art therapist and occupational therapist. The ward had three staffing shifts per day. The medical input was provided by a consultant psychiatrist three days per week, staff felt this was adequate and they confirmed they were able to access doctors when needed.

Assessing and managing risk to patients and staff

- We sampled all of the care records on Pavilion ward as all of the men were detained under the Mental Health Act 1983 and found a comprehensive risk assessment in place for all patients on admission. We found the risk formulations were good and used a recognised risk assessment tool (The five Ps) which all staff we spoke to had been trained to use. We saw evidence that risk assessments were reviewed as part of the multi-disciplinary care review process as detailed in the acute inpatient service operational policy.
- We found that blanket restrictions, such as room searches, access to cigarettes and lighters and locked doors to access and exit the ward doors where justified and clear notices were in place for patients explaining why these restrictions were being used.
- Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was safely managed. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of patients previous risk history as well as their current mental state.
- All staff had been trained in the use of physical interventions and understood that these should only be used as a last resort. We looked at the records of restraint which were of a good quality and set out as the standards in the trust's seclusion policy and procedure recommended.
- We noted that Pavilion ward had reduced rates of seclusion from 148 episodes in 2011 to less than 50 in 2014 (9 month period only in 2014). They had achieved this through the increased use of reflective practice and working with patients on reflections of their experience in seclusion to make positive experience changes. This work had come to the Department of Health attention and Pavilion ward had been asked to become members of their positive and safe champions' network, identifying good practice in PICU services.
- Where rapid tranquilisation was given, this followed NICE guidance.
- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. All staff had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy.
- We saw that patients received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations.
- Patients were provided with information about their medicines. Staff discussed changes to the patients' medicines with them and provided leaflets with more information.
- Our pharmacist inspector checked the management of medicines on Pavilion ward and found that appropriate arrangements were in place.

Track record on safety

- The recent incidents reported from Pavilion ward included two violent incidents and a fire started by a patient in the seclusion room.

Requires improvement

Are services safe?

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Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. All incidents were reviewed by the ward manager and forwarded to the general manager and matron for Mill View hospital. All incidents were electronically forwarded to the patient safety team (governance). The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these.
- We were told by the ward manager that lessons learnt from incidents were shared at the regular ward managers meetings facilitated by the matron and general manager for Mill View hospital.
- We looked at the serious incident briefing sent monthly to Pavilion ward with details of all incidents and learning identified with associated action plans for all wards at Mill View.

Are services effective?

Requires Improvement

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

Summary of findings

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

Our findings

Assessment of needs and planning of care

- The trust was using a mainly paper based system of recording the care given. Although some records were kept electronically the majority of records were paper-based. This led to variances in the quality of care recorded. Although the basic paperwork was the same there were differences in the filing and recording systems across the wards visited. The trust had plans to introduce complete electronic record keeping for adult services by Autumn 2015.
- At Meadowfields hospital and Oaklands ward we found that care plan documentation was variable. Some wards contained up to date, personalised and holistic care plans. These records clearly documented the patients' views and recorded that only those people the patient wished to be involved in their care were given access.
- Managers told us that although all the wards used the same template they did amend this. They told us that there was a pilot looking at addressing the anomalies identified between the care planning and the care reviews. For example if the doctor increases observations during a clinical review it may be some time before the care plan is amended to reflect this.
- On Rowan ward the care plans were holistic in nature and clearly documented the patients' views. We saw evidence that only those people the patient wished to be involved in their care were given access. However none of the records we reviewed were recovery focused.
- On Maple ward, in particular, the quality of assessment and care planning was poor and the records did not reflect the quality of care given. None of the care records we reviewed were recovery focussed. Feedback from patients indicated that they had little involvement in their care plan. Comments such as "I've seen it once" and "I don't know much about my care plan" were noted. For example all the care records we reviewed on Maple ward were incomplete. We identified several gaps with no changes to the care plans or risk assessments following review.
- At Meadowfields hospital and the Oaklands centre for acute care all the care plans we reviewed demonstrated that patient's physical health was taken into consideration. Patients received a physical health check on admission and their health was actively monitored throughout their stay in hospital through the Health of the Nation Outcome Scales (HoNOS) checks and regular health check assessments and observations which gave staff an early warning if a patient's physical health was deteriorating.
- At Mill View hospital, patients' needs were assessed and care was delivered in line with their individual care plans. Records showed that all patients received a physical health assessment and that risks to physical health were identified and managed effectively. We noted care plans were available for those patients with an identified risk associated with their physical health. However a caveat to this is that it was not easy to navigate care records and they were driven by process. The documentation did not highlight the personalised, holistic and recovery based approach, that we observed staff delivering throughout our time spent on Regency and Caburn wards. The care records did not focus on patients' strengths or aspirations. Advance decisions about their care and treatment were not documented.
- At the Department of Psychiatry and Woodlands Conquest hospital we found that care plans were personalised and detailed but lacked any evidence the patient had been involved in writing them. There was no evidence of how the patient wanted care delivered. The actions focused on what staff could do to help them. Some patients said they did not have a care plan whilst others said they had been given one by staff but had not been involved in writing it. There was no evidence of any advanced decisions. Daily records indicated a level of engagement with patients and entries were specific and detailed.
- During our last inspection of Langley Green in October 2014 we found that care records were disorganised, and information was difficult to find. At this inspection we found that the service had implemented a standard

Are services effective?

Requires Improvement

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template for care records. This had been implemented across all four wards, which were now in a clear order, and it was possible to easily find information about people's assessments and care plans.

- At Langley Green hospital patients had a physical healthcare examination on admission, and this was reviewed in the multidisciplinary (MDT) meetings. The service used a system called MEWS (Modified Early Warning Score) to monitor people's physical healthcare. This included recording routine observations such as blood pressure and temperature. The MEWS forms were colour coded and used a scoring system to identify when additional action may be required. However, although the records we saw had been completed correctly, we saw one record where a potentially concerning measurement had not been identified as such. This had been identified as a potential problem issue in the multi-disciplinary meeting three days later, and they had reported this back to the ward staff.
- A MEWs audit had been carried out which showed that many were not completed correctly. For example, on Amber ward 51% had been completed in August, 40% from September to November, and 54% in December 2014. There was an issue around training staff in the use of MEWS. Many of the permanent staff had had training, but the service used a significant number of agency staff who had not. The service had plans to address this by improving the MEWS form, training staff, and introducing a 'prompt' sheet for staff when completing the form.
- An audit in December 2014 showed that all patients reviewed had had a physical examination within 24 hours of admission, and had blood tests within 7 days.
- All care paper records were stored securely and were readily available for staff when needed.

Best practice in treatment and care

- At Meadowfield hospital and the Oakland's centre for acute care we reviewed medication administration records and found that they were not always completed accurately. For example the medicine records we reviewed on Maple ward were incomplete with administration gaps, incorrect spelling of medicines, weights and dates missing. There was little evidence of capacity and consent to treatment and little patient involvement documented in the medication charts we reviewed.
- Meadowfield hospital and Oakland's centre for acute care offered psychological therapies as recommended by NICE. Patients were able to access psychological therapies as part of their treatment. We were told that psychologists were available as part of the ward team and offered staff reflective practice opportunities although this was seldom taken up.
- We saw there were a range of therapeutic activities available to patients. This ranged from talking therapies to art, crafts, exercise and vocational support. Both hospitals had a gym and encouraged meaningful and purposeful activities to develop patients coping mechanisms, well-being and self-esteem. Meadowfield hospital employed a personal trainer who organised exercise and physical fitness sessions. We found that patients revived occupational and therapeutic interventions from passionate and committed staff.
- Patient feedback indicated there were a lot of "Good, worthwhile activities" and therapies to get involved in but there was less to do at the weekends. Managers acknowledged that there were more limited resources available at the weekends.
- At Meadowfield hospital patients did not always have access to prompt specialist nursing services such as podiatry, tissue viability, nutritional or diabetic support. This was because of historical differences in the provision of these services across the county and the trust did not have a current service level agreement with the local community NHS trust.
- Meadowfield Hospital operated a physically open door policy as part of their philosophy of care. Staff were committed to this and believed it reduced patients absconding.
- At Mill View hospital NICE guidance was followed in prescribing medication.
- At Mill View hospital patients had access to a good variety of psychological therapies as part of their treatment and psychologists, occupational therapists and art therapists were part of the multi-disciplinary team and actively involved.

Are services effective?

Requires Improvement

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- Evidence seen of adherence to Department of Health (2010) requirements that VTE risk assessments take place for every patient. Adherence to The National Institute for Clinical Excellence (2010) recommendations on VTE risk assessments.
- Evidence seen that the malnutrition Universal Screening Tool (MUST) had been carried out for all patients and associated care plans.
- The patients were assessed using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled clinicians to build up a picture overtime of their patients' responses to interventions.
- The modified early warning system (MEWS) to help monitor a patient's physical health care needs was fully implemented for all patients.
- Staff participated in a range of clinical audit to monitor the effectiveness of services provided. We saw the staff participated regularly in reflective practice sessions to also evaluate the effectiveness of their interventions.
- We saw that an acute and urgent care governance meeting was held monthly and was chaired by the acute care clinical lead. We saw that Regency and Caburn wards were represented at the meeting. Areas of best practice discussed included medication and associated protocols, the Mental Health Act, engaging family and friends through the use of the triangle of care. Others issues discussed were bed management, an audit on use of seclusion, physical healthcare and an interim report on the CQUIN key performance indicators.
- Regular audits took place which scrutinised adherence to physical healthcare CQUIN.
- We saw on both wards that the families and friends of patients are regularly asked for their feedback through the, "Family and Friends test."
- On Bodiam ward we reviewed some medication charts and saw medication was prescribed within recommended limits. Prescription charts were legible and the necessary legal authorities were attached to the medication cards.
- The patients we spoke to on Bodiam ward said there were insufficient groups and activities with one person saying "there is nothing to do". We were shown a copy of the ward programme but patients did not feel it met their needs. One person said they had never been able to use the gym equipment.
- On Heathfield ward there was a part time occupational therapist and a full time activities co-ordinator linked to the ward. We saw there was a full activities programme for the ward. Patients told us they enjoyed the activities, in particular, the quiz and crosswords. However one patient told us there was "not a lot to do".
- At Woodlands Conquest hospital we saw there were well equipped occupational therapy rooms and we observed some patients participating in an art activity. Patients were complimentary about the range of activities and the facilities available to them.
- At Langley Green hospital patients were referred for further assessment and treatment when they had physical healthcare problems.
- Clinical audits were carried out into the use of MEWS, the Mental Health Act, care plans, controlled drugs, HoNOS rating scales, and using the safety thermometer.

Skilled staff to deliver care

- At Meadowfield hospital and the Oakland's centre for acute care each ward had a dedicated multi-disciplinary team which included a ward manager, consultant psychiatrist, junior doctors, registered mental health nurses, nursing assistants, occupational therapists, therapeutic activity workers, pharmacists and housekeeping staff.
- At Meadowfield hospital and the Oakland's centre for acute care each ward held staff training records separately. On some wards these were held in paper format and others electronically. There was no link with the trust's training department who collated information separately. We noted that on the electronic system, infection control training was categorised as non-essential training and we queried this with the manager. The system did not alert managers when staff had completed any e-leaning and managers told us it was difficult to maintain a current picture of their staff's training and development needs.
- We found that the majority of staff at Meadowfield hospital and the Oakland's centre for acute care had not received mandatory training within the timescales set

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by the trust. This was highlighted in the NHS 2014 staff survey and confirmed by the electronic training records kept on the wards. We found that the majority of staff had not undertaken infection control, manual handling or life support training. There was no evidence that staff competencies and skills were monitored. In addition, the majority of staff had not received any supervision, appraisals or undertaken reflective practice in line with the trust's policy. Many staff had not received any formal support in the past year.

- The trust had identified that staff training, learning and development was a concern and had in place a strategy to address the issues. This included launching a new induction programme, to redefine core training, commission a learning management system and ensure that the majority of staff completed core training within the next eighteen months.
- At Mill View hospital, the staff on Regency and Caburn wards came from a variety of professional backgrounds and were all fully integrated into the service.
- We found that not all staff had updated mandatory training refresher courses recorded, with some staff still requiring mandatory training in infection control and hand hygiene. We did however find other areas of training that was at 100% such as basic food hygiene training and safeguarding vulnerable adults and children.
- Initiatives were in place at Mill View hospital to address the shortfall in staff mandatory training which included training all new staff during the trust induction by adding an extra day to the programme and the introduction of e learning.
- All staff we spoke to at Mill View hospital said they received individual supervision on a regular basis as well as an annual appraisal. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the ward.
- Both acute admission wards at Mill View hospital had a regular team meeting and all staff described morale as good with their team managers being highly visible, approachable and supportive.
- Senior managers told us they were performance managing a small number of capability issues at the time of our inspection.
- At the Department of Psychiatry members of the multi-disciplinary team included psychology and occupational therapy as well as nursing and medical staff. Patients told us there were activities available and these were relevant to their needs. Most patients told us activities were available seven days a week but one patient said there were currently less activities whilst a replacement occupational therapist was recruited. Patients told us staff were available to talk to at any time, and not just for scheduled one to ones. A support group for staff working with patients with personality disorder needs took place every two weeks which gave staff the opportunity to reflect on their practice.
- Staff presented as motivated and skilled. They told us there were opportunities available for further training and felt requests for additional training were supported
- At Langley Green hospital the service was staffed by a multidisciplinary team which included doctors, nurses, occupational therapists and assistants, and health care assistants. There was no access to psychotherapy on the wards. There was psychology input for assessment only, as there was only one psychologist for the whole unit.
- The trust had a central training department that provided staff with information about training, which could be booked online. However, at Langley Green, training records were not up to date, and there were differences between what was recorded centrally by the trust, and locally by individual managers. Many staff were out of date with Mental Capacity Act (MCA) and Mental Health Act training (MHA). Most staff had completed safeguarding training. Training in prevention and management of violence had not been completed by all staff, and some staff had had to wait several months to attend the training after starting to work for the trust.
- Staff had supervision at Langley Green hospital, though this did not always occur within the target timescale set by the trust. The recording of appraisals on the electronic record showed very few staff as having had an appraisal. However, staff and ward based paper records showed that some staff had had an appraisal, even though this was not reflected on the electronic record.

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- All medical trainees had an induction that included basic life support (BLS) and the legal aspects of mental health such as the MHA and MCA. All medical staff received regular supervision.

Multi-disciplinary and inter-agency team work

- At Meadowfield hospital and the Oaklands centre for acute care patients met with their consultant psychiatrist on a weekly basis at a clinical review and were visited during the week by a junior doctor. There was always a doctor on call throughout the day and night for urgent medical issues with a senior nurse practitioner available in the hospital.
- We observed holistic, effective and knowledgeable hand overs between shifts and healthcare professionals where information was presented and discussed. Staff used a printed handover sheet which identified the patient, their diagnosis, past and present risks, any comments and things to do during the shift. For example on Oaklands ward we saw the hand over sheet informed staff of the door status of the ward and the reason for this, observations that were needed, medication and the patients current mood and presentation. In addition each day a daily ward planning meeting was held with patients and staff. This was an informal meeting, over a cup of tea or coffee, where staff and patients met to plan the activities and groups for the day. This was also an opportunity for patients to discuss any issues in an open environment. Separate times were tabled for one to one meetings with staff for therapeutic discussions.
- We saw that the crisis teams, care co-ordinators and local authority, social services, were involved in the assessment, planning and delivery of people's care and treatment. At Meadowfield hospital and the Oakland's centre for acute care, members of the crisis teams visited the wards regularly and helped in co-ordinating patients discharge to home arrangements. This was important as the trust had identified that the number of patient suicides within three days of discharge from hospital in 2013/2014 was an elevated risk. Involving the Crisis Team closely in planning for discharge meant that potential risks were identified early.
- At Mill View hospital, The Department of Psychiatry and Woodlands Conquest hospital, we found fully integrated and adequately staffed multi-disciplinary teams. Regular and fully inclusive team meetings took place. We observed care reviews on all wards and found these to be effective and involved the whole multi-disciplinary team.
- We observed inter-agency working taking place, with care co-ordinators attending meetings as part of patients' admission and discharge planning.
- We saw from care records looked at that GPs receive timely discharge summaries and that the consultant psychiatrist was in regular contact with GPs.
- We saw that a monthly liaison meeting was held with the police looking primarily at use of the place of safety however, all incidents involving the police and any general security issues at Mill View hospital were explored and discussed.
- At Langley Green hospital there was a daily handover meeting on weekdays, attended by the multi-disciplinary and the crisis response team. There were multi-disciplinary team meetings on each of the wards once or twice a week. Patients were seen or had their care reviewed by the team during these meetings. A pharmacist also attended some of these meetings to provide advice about medication.
- At the beginning of our inspection there were 11 GP discharge summaries that had not been completed for patients on Coral ward, some dating back to August 2014. This meant that GPs may not have the necessary information about patients who had been discharged back into the community. By the end of our inspection, there were only two outstanding discharge summaries, for patients who had been recently discharged

Adherence to the MENTAL HEALTH ACT 1983 and the MENTAL HEALTH ACT 1983 Code of Practice

- The trust had informed CQC that 100% of records for all Mental Health Act event episodes had errors. This was identified as a reporting error and flagged as an elevated risk as data quality had a direct impact on health and social care.
- However on Maple, Rowan and Oaklands wards with few exceptions, we found the legal paperwork was generally in good order. The approved mental health professional reports were available and there was evidence that patients had had their rights discussed with them on admission and regularly afterwards on most wards.

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Section 17 leave forms were generally in good order. The documentation on Maple ward showed some gaps which did not demonstrate full compliance with the Mental Health Act 1983 and accompanying Code of Practice. For example many of the consent to treatment forms were incomplete and lacked patient involvement. In all relevant cases on Maple ward, there were no approved mental health professional reports on the patient's notes. The care records on Maple ward did not provide evidence that patients had had their rights discussed with them on admission and regularly afterwards. In one case the Section 17 Leave form was poorly completed with unclear conditions and the length of the leave not recorded. There was no evidence that patients and their relatives had been given copies of their leave forms.

- The trust had flagged difficulties in arranging GP services for detained patients as a risk at Meadowfield Hospital. We found that this was a particular problem where patients were accommodated out of area.
- We checked all the files of the detained patients on Regency and Caburn wards to ensure that appropriate documentation was in place to reflect what was required in the Mental Health Act and Code of Practice and in most cases this was correct. All detentions were legal. A weekly ward audit of MENTAL HEALTH ACT 1983 paperwork had been introduced and this enabled staff to ensure that the requirements of the act were being met.
- At Mill View hospital conditions of Section 17 leave were being recorded and reviews of risk carried out prior to leave. Capacity and consent was being assessed and recorded on admission and within the first three months prior to the statutory requirement to do this which was good practice and in line with the Code of Practice. Section 132 rights were found in most cases being given and recorded in line with the trust policy.
- Care plans at Mill View hospital were not designed to be patient led and contained language and "jargon" that patients may not understand, such as abbreviations (without explanation) and medical terminology. The care plans did not show involvement of or include the strengths of the patient. There was no evidence found in care plans or within the notes regarding statements being made by detained patients with regard to their preferences for what they would or would not like to happen. This included legally binding advance decisions to refuse treatment and "wishes expressed in advance" in line with the Code of Practice – Chapter 17.
- At Mill View hospital good signage was observed throughout the wards offering informative information for patients and carers including information regarding Independent Mental Health Advocacy Services which was noted as being readily available for patients and advocates visited the ward on a daily basis which was noted as good practice. Notices were in place on exit doors for informal patients who wished to leave the ward.
- At the Department of Psychiatry and Woodlands Conquest hospital staff demonstrated a good understanding of their responsibilities in relation to the Mental Health Act 1983 and the Code of Practice. Patients told us staff explained their rights to them on a regular basis and we saw there were records to support this. There were regular audits carried out to monitor compliance with the Mental Health Act 1983. Information about the Independent Mental Health Advocacy Service was displayed, although one of the notices did not have any contact details for the service. Patients we spoke with confirmed they were able to contact an advocate if this was needed. All paperwork viewed was appropriate and in good order.
- At Langley Green hospital, Mental Health Act documentation was in good order. There was evidence that patient's capacity to consent to treatment was assessed on admission and regularly thereafter. There was evidence that patients were regularly informed of their rights as required by section 132 of the MHA.
- Training logs indicated that not all staff had received up to date MHA training at Langley Green hospital.
- Independent Mental Health Advocates (IMHA) were involved with patients and there was information on the ward about this service. Some staff did not have a clear understanding of the role of the IMHA.

Good practice in applying the MCA

- Patients' capacity to consent to treatment was assessed on admission and regularly reviewed. We found that the reasons for the decision were generally well documented. The requirements of Part IV of the Act with regard to medical treatment were generally complied with.

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- We found that on Oaklands ward patients who were not detained were prevented from leaving the ward for 24 hours or longer. It was not obvious from the records we reviewed or the patients that we spoke with that they had consented to remain on the ward for this period or were aware of this condition when they agreed to be admitted to the unit.
- We found one example on Oakland's Ward where there was no legal authority to administer medication despite it being 10 days since the patients community treatment order had been revoked. This issue was resolved during our inspection.
- At Langley Green hospital training logs indicated that many staff had not received Mental Capacity Act (MCA) training. Many staff we spoke with did not have a clear understanding about the MCA and (DoLS). Advice on the Mental Capacity Act was available from the Mental Health Act administration office.
- In all other wards staff had a clear understanding about the MCA and DoLS.

Mill View psychiatric intensive care unit (PICU)

Assessment of needs and planning of care

- Patients' needs were assessed and care was delivered in line with their individual care plans. Records showed that all patients received a physical health assessment on admission to Pavilion ward and that risks to physical health were identified and managed effectively. We noted care plans were available for those patients with an identified risk associated with their physical health. The assessment was reflected in a "physical health care plan" which was monitored on a daily basis. Staff felt quite satisfied that they were attending to patients needs on a holistic basis and one patient who had had a recent "heart attack" told us he felt re-assured that if he needed urgent medical treatment he would receive this.
- Care record documentation was not easy to navigate and was driven by process. The documentation did not highlight the personalised, holistic and recovery based approach that we observed staff delivering throughout our time spent on Pavilion ward. The care records did not emphasise patient's strengths, aspirations or any advanced decisions about their care and treatment.
- All care paper records were stored securely and were readily available for staff when needed.

Best practice in treatment and care

- Staff followed NICE guidance in prescribing medication.
- Patients had access to a good variety of psychological therapies as part of their treatment and psychologists, occupational therapists and art therapists were part of the multi-disciplinary team and actively involved.
- Pavilion ward had full accreditation to the National Association of PICUs.
- Evidence seen of adherence to Department of Health (2010) requirements that VTE risk assessments take place for every patient. Adherence to The National Institute for Clinical Excellence (2010) recommendations on VTE risk assessments.
- Evidence seen that the malnutrition Universal Screening Tool (MUST) had been carried out for all patients and associated care plans.
- The patients were assessed using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled clinicians to build up a picture overtime of their patients' responses to interventions.
- The Modified Early Warning system (MEWS) to help monitor a patient's physical health care needs was fully implemented for all patients.
- Staff participated in a range of clinical audit to monitor the effectiveness of services provided. We saw the staff participated regularly in reflective practice sessions to also evaluate the effectiveness of their interventions.
- We saw that an acute and urgent care governance meeting was held monthly and was chaired by the acute care clinical lead. We saw that Regency and Caburn wards were represented at the meeting. Areas of best practice discussed included medication and associated protocols, the Mental Health Act, engaging family and friends through the use of the triangle of care. Others issues discussed were bed management, an audit on use of seclusion, physical healthcare and an interim report on the CQUIN key performance indicators.
- Regular audits scrutinised on adherence to physical healthcare CQUIN.
- Regular audits scrutinised on use of seclusion.

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- We saw on Pavilion ward that the families and friends of patients are regularly asked for their feedback through the, "family and friends test." We noted that PICU was an early adopter of this electronic feedback method.

Skilled staff to deliver care

- The staff on Pavilion ward came from a variety of professional backgrounds and were all fully integrated into the service.
- We found that not all staff had updated mandatory training refresher courses recorded, with some staff still requiring mandatory training in some areas.
- Initiatives were in place to address the shortfall in staff mandatory training which included training all new staff during the trust induction by adding an extra day to the programme and the introduction of e learning.
- We noted Pavilion ward had a detailed 10 week induction to PICU programme available for all new staff.
- All staff we spoke to said they received individual supervision on a regular basis as well as an annual appraisal. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the ward.
- Pavilion ward had a regular team meeting and all staff described morale as good with their team manager being highly visible, approachable and supportive.
- Senior managers told us they were actively managing a small number of long term sick leaves at the time of our inspection.

Multi-disciplinary and inter-agency work

- We found a fully integrated and adequately staffed multi-disciplinary team. Regular and fully inclusive team meetings took place.
- We observed inter-agency working taking place, with care-coordinators attending meetings as part of patients' admission and discharge planning.
- We saw from care records looked at that GPs receive timely discharge summaries and that the consultant psychiatrist was in regular contact with GPs.
- We saw that a monthly liaison meeting was held with the police looking primarily at use of the place of safety however also all incidents involving the police and any general security issues at Mill View hospital.

Adherence to Mental Health Act 1983 and the Code of Practice

- We checked all the files of the detained patients on Pavilion ward to ensure that appropriate documentation was in place to reflect what was required in the Mental Health Act 1983 and Code of Practice and in most cases this was correct. The trust could demonstrate that there is a systemic process in place to ensure that the operation of the Mental Health Act meets legal requirements. All detentions were legal. A weekly ward audit of Mental Health Act 1983 paperwork had been introduced and this enabled staff to ensure that the requirements of the 'act' were being met.
- Good conditions of Section 17 leave were being recorded and reviews of risk carried out prior to leave. Capacity and consent was being assessed and recorded on admission and within the first three months prior to the statutory requirement to do this which was felt to be good practice and in line with the Code of Practice. Section 132 rights were found in most cases being given and recorded in line with the trust policy.
- Care plans were not designed to be patient led and contained language and "jargon" that patients may not understand, such as abbreviations (without explanation) and medical terminology. The care plans did not show involvement of or include the strengths of the patient.
- There was no evidence found on care plans or within the notes regarding statements being made by detained patients with regard to their preferences for what they would or would not like to happen. This included legally binding advance decisions to refuse treatment and "wishes expressed in advance" in line with the Code of Practice – Chapter 17.
- Good signage was observed throughout the wards offering informative information for patients and carers including information regarding Independent Mental

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Health Advocacy Services (IMHAs) which was noted as being readily available for patients and advocates visited the ward on a daily basis which was noted as good practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- No patients on Pavilion ward was being treated under Section 5 of the Mental Capacity Act.
- There were no current DoLs applications.

Good

Are services caring?

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

Summary of findings

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

Our findings

Kindness, dignity, respect and support

- At Meadowfield hospital and the Oakland's centre for acute care, in general, we saw that staff were kind and compassionate when interacting with patients offering appropriate emotional and practical support where necessary. We noted that on all the wards the staff were visible and actively engaging in a friendly manner with patients. Patients told us "It's nice here". We observed staff de-escalated situations by engaging with patients in a quiet and supportive manner. We saw a patient who was acutely angry and distressed taken to their bedroom for de-escalation in the least restrictive way possible and then quietly offered support until they had calmed down. Patients in general were genuinely happy with the care they received from the nursing and support staff. Patients told us the staff were "Wonderful" and "They really care – although they are busy it's a heart-felt service".
- However several patients remarked that the consultants "Don't listen to me" or "The consultants are patronising, although the junior doctors are more helpful".
- We attended Holy Communion with a group of patients from Meadowfield Hospital. Patients told us they found the service "Uplifting" and very helpful. Staff were understanding of the personal, cultural and religious needs of patients.
- Patients in general were happy with the care they received. One patient was impressed by the staff on Maple ward who were asking how their fish would be cared for while they were in hospital. Another told us that, "All the staff are good but some are very good".
- However on Maple ward we heard staff refer to patients by their diagnosis and not their names, with the expectation they would be readmitted. This lacked respect and the ethos of hope and recovery.
- We spoke with patients on Rowan ward who told us that the staff attitude was "Brilliant". One patient told us that the staff "Treat me like a human being; they always have time to spend with me". Another patient told us the staff were always polite and respectful.
- One patient on Oaklands ward told us that staff were "really nice" and they "go out of their way to make sure that you are okay" and that she "liked this hospital." Another patient told us that she knows the staff on the ward well and that if she has to be in hospital she would rather be on this ward.
- Most of the patients we spoke with at Mill View hospital were complimentary about the staff providing the service on both Regency and Caburn wards. Patients were supported by kind and respectful staff. We received some adverse comments on Regency ward which were fed back to the manager who took immediate action to rectify the issues identified.
- One patient we spoke to said, "The staff here actually notice your mood and enquire about it, no matter how busy they are. They all do this consistently and it makes such a difference. They really do care and it's genuine." Another patient said, "This is the best care I have ever had, anywhere. It is to be commended." Another patient said, "The staff are all compassionate, every one of them. I feel so safe, cared for and it is having such a good effect on my mood. This team are just wonderful, I can't praise them enough."
- We saw that staff showed patience and gave encouragement when supporting patients. We observed this consistently on both Regency and Caburn wards.
- We saw staff were calm and not rushed in their work so their time with patients was meaningful. Patients commented on the, "Kindness and compassion" of the staff. We saw that staff were able to spend time individually with patients, talking and listening to them.
- During our inspection we saw a lot of positive interaction between staff and patients on the ward. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time. We saw one interaction where a nurse saw that a patient was at the first stage of getting distressed. Despite being in conversation with our inspectors, the nurse attended immediately to the patient in a kind and gentle manner.

Good

Are services caring?

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The patient visibly relaxed after the intervention. This staff member had also been commended to us by both a patient and a relative as being particularly kind and perceptive.

- At the Department of Psychiatry we observed positive interactions between staff and patients, interactions suggested good rapport had been established. Staff spoke to patients in a friendly and courteous way and about patients in a professional and supportive way.
- One patient at the Department of Psychiatry described the staff as, "Outstanding" but said it was difficult to speak with a nurse during handover time. Another patient told us they felt staff were respectful. One patient said they felt they had a good relationship with their doctor and felt listened to by them. One patient told us staff were, "Pretty good", "A busy bunch" and described staff as, "Skilled".
- Some patients had left comment cards, and, for those who specified a ward, the comments for Heathfields were positive and included, "The care was exceptional. The staff are kind and helpful" and another said, "All staff were caring, very supportive and were extremely patient to the needs of every patient." One patient, however said,"They make me eat when I don't want to sometimes…I feel that I am not really getting better".
- Patients told us staff were mindful of their dignity and privacy needs and confirmed staff knocked before entering bedrooms. Patients said they felt staff were caring and interested in their well-being.
- At Langley Green hospital the interactions we observed between staff and patients, particularly on Jade and Coral wards, were respectful and positive. The atmosphere on the wards was generally calm. The patients we spoke to on all the wards had differing views about the attitude of staff towards them. Some patients found some staff, "Caring, kind and helpful". They found other staff, "Disinterested, rude and patronising."

The involvement of people in the care they receive

- Each ward had a welcome pack which gave an introduction to the hospital and useful information to help patients on their first few days following admission. We saw that there was admission process that informed and orientated patients to the wards.
- Friends, families and advocates were actively involved as appropriate and in accordance with the patients' wishes. Relatives, partners and carers were able to attend clinical reviews with the patient's agreement.
- We saw that on Oaklands and Rowan wards staff actively involved patients in their care and support. Although this was not always well documented, patients confirmed that the staff supported them in making decisions when needed.
- The hospitals had facilitated monthly meetings of an independent mental health charity where patients were encouraged to meet and give feedback on their experience. The meetings were led by volunteers with no hospital staff present. Anonymous feedback was given to the hospital matron following the meetings if indicated.
- There were information posters and literature available on the advocacy services available for patients. We spoke with the Independent Mental Health Advocate who regularly spent time at Meadowfield Hospital. They visited the hospital on a weekly basis and supported patients in their dealings with the trust.
- There were also feedback boxes for patients and visitors to leave comments on the hospital and care provided.
- We found that staff were kind, caring and built positive relationships with patients, their families and carers. All the patients we spoke with told us they felt involved in their care. We saw minutes from patients meetings which confirmed that patient's felt they were supported to remain in contact with their families. Comments such as 'care and access for friends and family is wonderful', ''there is good access for friends and family and brilliant care", together with praise for the family room at Meadowfield hospital were noted.
- The hospital told us they worked collaboratively with families and cares in supporting patients. Part of this included working with the local carer support group. Carers groups were held at Meadowfield hospital on a monthly basis. However one manager we spoke with did not have local knowledge about local self-help groups or what was available. There were no minutes of these meetings available or information on display about their work.

Good

Are services caring?

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- At Mill View hospital we saw that information booklets were given to all patients on admission to Regency and Caburn wards. This included contact information on local advocacy services and MIND in Brighton and Hove who provided a once monthly meeting on the wards to discuss any concerns any patients may have had.
- We saw evidence that patients were encouraged to join the recruitment process assessment centre to appoint substantive staff at Mill View hospital.
- We saw evidence of patient involvement in the care records we looked at. We also saw that family and friends had contributed to gathering comprehensive life histories of patients which included their likes and dislikes.
- We saw that Mill View hospital was implementing the triangle of care initiative to ensure a carer champion was visible and in good communication with families and friends. We also noted a carer information board in the main corridor of Mill View. We saw that the wards were asking family and friends for feedback via an electronic tablet, called, "The family and friends test."
- During our inspection we were asked to join a multi-disciplinary care review meeting on both Caburn and Regency wards where the views and wishes of the patient were discussed with them. Options for treatment were given to the patients to consider at both meetings.
- There was no evidence of advance decisions in the care records scrutinised at Mill View hospital.
- At the Department of Psychiatry patients told us they were given information about the ward on admission. They told us they felt involved in clinical review meetings but none of the patients we spoke with said staff had discussed their care needs with them. They told us staff gave them a copy of their care plans but they had not had any input into them. There was no evidence of any advance decisions in place.
- We spoke to a relative who described staff as, "Really caring and compassionate" and told us, "It is the little things that make the difference". They felt staff were knowledgeable and had taken time to really get to know and understand the patient. They also appreciated the time staff gave them and felt fully involved in decisions being made about their relative. They told us they were, "Very thankful for the way Bodiam staff are".
- Patients at the Department of Psychiatry were invited to give feedback about aspects of their care and treatment on an Ipad on a weekly basis.
- At Woodlands Conquest hospital patients were encouraged to express their views and we saw there were boxes on the walls where patients could post their comments. There was a "you said and we did" board and we noted patients had requested a newspaper which was being provided as a result.
- At Langley Green hospital some of the care plans were signed by patients, but most did not explicitly include their views. Some of the patients we spoke with had copies of their care plan, or were aware of its contents, and in some cases had disagreed with the plan. There were some positive examples where patients had been actively involved in writing their own care plan. However, many patients did not have a copy of or know what was in their care plan. Some patients told us they had changed their plans, for example by not wanting specific medication. However, most patients were not actively involved in their care planning.
- There were weekly community meetings on each of the wards at Langley Green hospital, where patients could give feedback and raise complaints about the ward. There was also a daily "coffee morning" where patients mainly planned their day, but they could also raise any problems. For example if a repair was needed in their bedroom.
- Each ward had an electronic tablet that patients could use to give feedback about the service. It included the "friends and family test", which broadly asks if you would recommend the service to others. This was primarily intended for use when patients were discharged, but was also used during a patient's admission to get ongoing feedback.

Mill View Hospital- Psychiatric Intensive Care Unit

Kindness, dignity, respect and support

- All of the patients and relatives we spoke with were complimentary about the staff providing the service on Pavilion ward and we saw that patients were supported by kind and respectful staff.

Good

Are services caring?

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

- Many patients wanted to speak to us in order to feedback their thoughts and experiences of the Pavilion staff team.
- One patient we spoke to said, "I have been in other PICUs and I can honestly say I have never been treated with such kindness as I have here. It's not just a couple of nice staff but all of them." Another patient said, "One week ago I was a complete wreck and the staff have helped me turn myself around. They are wonderful, I'm not exaggerating when I say they are the best, fantastic and so very well led by the manager." Other patients interviewed told us that the care and treatment they were receiving was "very good", one patient said that the care is "out of this world!" Another patient compared his care with admissions to other hospitals in the trust and said there was, "no comparison."
- Staff told us they, "Felt proud" to be working on this unit. We were told that staff found the atmosphere on the ward, "Very therapeutic and calming." This was despite the often challenging and distressing behaviour of some of the patients. They felt they were well supported by the ward manager and the management team within the trust and felt able to raise issues if they had any concerns.
- One family member of a patient on the ward said, "The staff have looked after my relative as well as I would have done myself; just like it was one of their own family members. They have supported me so well. They have gone beyond the call of duty and at a time of extreme crisis in my relative's life. Fantastic really."
- We saw that staff showed patience and gave encouragement when supporting patients. We observed this consistently on Pavilion.
- We saw staff were calm and not rushed in their work so their time with patients was meaningful. Patients commented on the, "Kindness and compassion" of the staff. We saw that staff were able to spend time individually with patients, talking and listening to them.
- We noted that all the staff we met were caring, committed and passionate about this ward and the patients detained within it. Despite being a PICU ward the atmosphere on the ward was calm, well managed and according to the patients and carers very therapeutic.
- During our inspection we saw a lot of positive interaction between staff and patients on the ward. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.
- We saw an example of one interaction when a patient said another patient was, "In my space." We saw a staff member intervene immediately and distract the patient, gently and swiftly, resolving the issue within seconds.
- We saw a series of proactive interventions whilst interviewing staff members. At every raised voice a member of staff excused themselves and went immediately to see what, if anything was taking place. This was repeated on a few occasions and we saw swift and gentle enquiries made each time. We saw that this proactive de-escalation resulted positively with every intervention and we thought this was an excellent approach which further highlighted the culture on the ward of egalitarian practice and respectful, caring interventions at any juncture.

The involvement of people in the care they receive

- We saw that information booklets were given to all patients on admission to Pavilion ward.
- This included contact information on local advocacy services and MIND in Brighton and Hove who provided a once monthly meeting on the ward to discuss any concerns any patients may have had.
- We saw that patients on Pavilion ward had contributed to the design of the ward and the seclusion room through an experienced based co-design project.
- We saw that Pavilion ward were working with a service user consultant and patients to maximise the therapeutic environment of the extra care, "Calm room."
- We saw evidence that patients were encouraged to join the recruitment process to appoint substantive staff.
- We saw that Pavilion ward had implemented the triangle of care initiative to ensure a carer champion was visible and in good communication with families and friends. We also noted a carer information board in the main corridor of Mill View. We saw that the wards were asking family and friends for feedback via an electronic tablet, called, "The family and friends test."

Good

Are services caring?

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

- There was no evidence of advance decisions in the care records scrutinised.

Requires Improvement

Are services responsive to people's needs?

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

Summary of findings

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

Our findings

Access, discharge and bed management

- Patients were not always able to access care as close to home as possible. Bed shortages across the trust meant that patients from other areas were often accommodated in Maple, Rowan and Oaklands wards. Although the wards we visited were full, few patients were people detained under the Mental Health Act (1983). For example on Oakland's Ward of the 16 patients admitted only four were patients detained under the Mental Health Act 1983.
- The number of patients placed out of Sussex for emergency mental health treatment had increased in recent years. The number had increased from 90 in 2012 / 2013 to 227 patients transferred out of county due to no suitable place of treatment closer to home in 2013 / 2014. Managers told us that they received daily updates on the number of patients out of area. On the day of inspection there were 16 patients in the Oakland centre for acute care and Meadowfield Hospital out of area.
- We found that patients were often moved between wards or transferred between locations several times before accessing appropriate care close to their home. Staff told us this was due to a lack of suitable beds across the region.
- There were no mental health intensive care beds (PICU) in the local area which meant that patients who required the additional support of PICU had to be admitted to a facility between 18 to 40 miles away. This meant it was not always possible for patients to maintain contact with family and friends.
- Discharge was often delayed because of lack of suitable accommodation. On Oaklands ward we saw patients actively involved in their discharge planning.
- In the six months to September 2014 the trust reported 132 delayed discharges from 22 wards. The trust had identified that the most common areas contributing to delayed transfers of care in the past 12 months were: availability of residential care home placement, housing difficulties and completion of assessment. We spoke with members of the crisis team, ward managers and the Independent Mental Health Advocate who confirmed that lack of suitable accommodation was a serious concern. However there was a lack of interaction and involvement between the various agencies involved. We were told that there needed to be stronger links built between the mental health trust and the various housing agencies.
- The proportion of patients followed up within seven days of discharge was in line with the England average of 97%. Patients valued the contact following discharge. We spoke with one patient who had been readmitted since a stay in hospital the previous month. The patient had not been contacted within seven days of discharge as his care coordinator was on leave. The patient felt that the lack of support had contributed to his readmission.
- At Mill View hospital, both Regency and Caburn wards were at full capacity when we inspected. We noted both acute admission wards had strong relationships with both the homeless and substance misuse teams which aided timely discharge when clinically appropriate.
- We attended a Mill View bed management meeting which was held twice weekly with both inpatient and community teams to monitor and track appropriate bed usage and to identify pressures on the system. We noted at the time of our inspection there were three patients in extra contractual, out of area admissions and four patients experiencing a delayed discharge from Mill View hospital. We found the bed management meeting also monitored all actual and potential inpatient delayed discharges. Resources were then deployed to assist in discharging patients in a timely manner to suit clinical need. We interviewed the Mill View bed manager who oversaw the system and monitored processes and appropriate admission criteria. We also interviewed the Mill View unit Co-ordinator who also advised on best use of resources including bed usage.
- On Bodiam and Amberley wards at the Department of Psychiatry we were told patients were often admitted to the ward from other geographical areas within the catchment of the trust. Patients told us this caused

Requires Improvement

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them difficulties with accessing visitors. This was the case too at Woodlands Conquest hospital. On the day of the visit, one person was being transferred back to their host ward because a bed had become available.We did not find any evidence that beds were not available for patients on return from periods of leave. At the clinical review meeting ongoing care needs were discussed and patients told us they had some idea of the likely duration of their inpatient stay. One person told us the staff's view differed from theirs about the need for inpatient care and another said they were expecting to be in hospital for "possibly a couple of months". Staff told us there were no patients whose discharge was delayed at the time of the visit.

- Patients from other localities were often admitted to Heathfields ward, at the Department of Psychiatry, and, some clinical staff identified this as a problem. We were not told of any difficulties with accessing a bed when patients returned from a period of leave. We were also told there were high numbers of re-admissions to the ward within a short period of time after discharge. We were also told there was a lack of specialist services for people with personality disorders throughout the service. We were told of difficulties in discharging patients because of a lack of suitable accommodation.
- We were told at Langley Green hospital that there were bed pressures on the service, which included patients waiting to find suitable alternative accommodation and others waiting to return to the hospital. However, there was a process for managing and reviewing this, and it was not raised as an issue with us by patients or staff. There were patients in out of area placements. Some of these were for "specialist" care and treatment that was not available in the trust, but others were in acute or forensic placements and were to be returned to the trust when beds were available. Senior managers and ward managers were very knowledgeable about these patients, and identified why they had been admitted, their length of stay, and any blocks to them returning to the unit.
- At Langley Green hospital there were weekly bed management meetings with senior and ward managers, and staff from the community and crisis teams. They discussed availability of beds, who was ready for discharge, and where patients were placed elsewhere when they could return to the unit if this was suitable.
- Patients who needed a psychiatric intensive care unit (PICU) bed were admitted to Amber ward in the unit. Coral ward admitted patients who lived in Surrey. If they required a PICU this could be delayed, as they would be transferred to a PICU in Surrey which was 18 miles away.

The ward environment optimises recovery, comfort and dignity

- We found that both Meadowfield Hospital and Oakland's centre for acute care provided a full range of therapeutic rooms and equipment to support treatment and care. For example both hospitals had art and therapy rooms, a spiritual room, laundry and kitchen facilities, a gym, a family room together with clinical treatment rooms and quiet rooms. Oaklands ward had a well-used multisensory room and Meadowfield hospital had a café for the use of patients, staff and visitors.
- Most of the ward environments were in good repair and provided a therapeutic environment however we noted that Maple ward was generally in poor repair with the environment requiring refurbishment and redecoration.
- All wards had quiet areas where patients could meet visitors. Meadowfield hospital had therapeutic areas off the ward where patients could socialise, engage in therapeutic activities or meet visitors if their condition allowed.
- We found the ward payphones were situated in communal areas of the wards which meant that patients could not make phone calls from these pay phones in private.
- All patients had access to outside areas for therapeutic activities and fresh air. Oaklands ward had a particularly well equipped outside area with facilities for engaging in table tennis or social activities.
- We saw that there was a range of information available on treatments, medication, the services offered at the hospital and local services together with information on patients' rights and how to complain. Oaklands ward in particular had local information available in easy to access formats.
- Patient feedback about the quality of food at both Meadowfieldshospital and Oaklands ward was variable. Some told us it was "Excellent" or generally "Ok" while others reported it was "Not good – no variety and little choice". The ward staff provided breakfast and a light

Requires Improvement

Are services responsive to people's needs?

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lunch of baked potatoes or sandwiches. However patients commented that the lunchtime menu did get, "Monotonous." One patient reported "It gets boring especially if you are in for a while, just soup, sandwiches or a jacket potato". A hot meal was provided in a ready meal form for the staff to reheat and serve in the evenings. There was a 'Patient's pantry' located on each ward where patients had access to hot drinks and snacks throughout the day and night if needed.

- We found that in general blanket restrictions were only used when justified. Meadowfield hospital was open with an unrestricted access policy. We observed how this was managed in practice with staff using therapeutic relationships to maintain safety. This meant that informal patients could access the café and activities off the ward as indicated by their risk assessment and care plan.
- Staff were aware of the rights of informal patients to leave at will. However we found that on Oaklands ward all patients were restricted from leaving the ward in the first 24 hours of their admission and were required to have a risk assessment before they could be given leave from the ward. We did not see any evidence that patients were informed about these restrictions prior to consenting to admission.
- We saw little evidence of patients personalising their rooms although there were pin boards available in the bedrooms. However we noted that the length of stay in both Meadowfields and Oaklands hospitals was short with patients not staying long. The advice for patients coming into hospital was not to bring too many belongings as storage space was minimal. We spoke with one patient who told us staff said he could bring in possessions as long as they were not breakable and did not pose a hazard. Patients accessed their room with the use of a personalised key fob. This meant they could keep their possessions safe.
- We saw that visiting times for family and friends was 10.00am to 8.00pm seven days a week. This meant that patients who had relatives, friends and carers who lived nearby were able to maintain contact with them.
- At Mill View hospital Regency and Caburn wards had a full range of rooms and equipment available including spaces for therapeutic activities and treatment.There were quiet rooms available where patients could meet visitors. Patients were able to make a phone call privately.
- There was direct access to garden areas on both wards. The garden on Caburn ward was in need of re-design and a planning application had been submitted to enable a more secure perimeter fence to be erected. This followed learning from a serious untoward incident which had happened in the Caburn ward garden.
- At Mill View hospital the food quality was good and a range of food and beverages were available over a 24 hour period.
- Patients at Mill View hospital were able to store their possessions securely in their bedrooms.
- Daily and weekly activities were advertised and available on the ward. In addition Mill View hospital had a good range of activities and groups available to patients from both wards. The activities were varied, recovery focussed and aimed to motivate patients. We saw that the activities programme covered the weekend periods. An occupational therapist was available on a full time basis and art therapy sessions were also available on both wards and we saw they operated a recovery star model which focussed on a holistic, person centred and recovery based approach. We saw that patients also had access to a recovery college.
- At the Department of Psychiatry, Heathfields ward, the ward appeared clean but appeared 'tired'. We were told the environment had improved with the recent delivery of new furniture. Patients were satisfied with the quality of the food and told us snacks were available if needed. Patients had a choice of meals from a set menu.
- Bodiam ward at the Department of Psychiatry was spacious and light. We saw there were three lounge areas and as well as smaller interview or quiet rooms. Access to outside space was from the ground floor and none of the patients reported any difficulties with accessing fresh air. We noted that some of the bathrooms and toilets were kept locked by staff but none of the patients reported this as a problem.There was a pantry for patients to make drinks and we were told this was open at all times. Snacks were provided and the last one was at 9pm. Patients were generally positive about the food with one person describing it as

Requires Improvement

Are services responsive to people's needs?

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"lovely" and another said it was "fine". A choice of meal was available but it depended where in the queue you were as to the amount of choice. Fresh fruit was available at meal times.

- The ward was mostly short stay and there was little evidence that patients had chosen to personalise their bed space to any degree. A small safe was situated inside each patient's wardrobe. Bedroom doors could not be locked. However none of the patients we spoke with said they had experienced any losses of thefts of their belongings. Most patients told us they felt safe on the ward but one patient described the dormitories as "frightening".
- Amberley ward at the Department of Psychiatry was spacious with several quiet areas and lounges. The gardens were accessed on the ground floor and we saw patients being able to move freely throughout the premises during the visit. Drinks were available 24 hours a day and a snack was offered at 9pm. There were vending machines on the ground floor where patients could purchase other items if they wished to do so. Patients were generally complimentary about the quality and choice of meals.
- At Langley Green hospital there were meeting and interview rooms on the wards for individual and group meetings. There was a female-only lounge on each of the wards. There was a family room for patients to use with children – this was within the hospital, but not on any of the wards.
- There was a payphone in the corridor, which gave only provided limited privacy. However, most patients used their own mobile phones.
- Each ward had its own garden. These were used by smokers, and there were lots of cigarette butts on the floor, particularly by the doors which provided shelter.
- Patients told us that the food was "okay" or good. There was vegetarian food available. The menu was on display on the wards. Patients had access to water and hot drinks 24 hours a day. There was fresh fruit available on some of the wards.
- All bedrooms had individual security access by patients, ensuring their belongings were secure. Patients were able to personalise their bedrooms.
- There was a therapy timetable on display at Langley Green hospital. There were activities for patients which included a gym, relaxation, and arts and crafts. There was a "coffee morning" meeting each morning, where staff discussed their plan for the day, and the activities they wanted to engage with. We observed activities on some of the wards during our inspection, but we observed no activities during our time on Amber ward (PICU). There were no activities available in the evenings and at weekends.
- There were clinical rooms on each of the wards for patients to have physical examinations, blood tests and electrocardiograms (ECGs). There had been problems with the ECG machines which had caused delays. However, new machines arrived during our inspection.

Meeting the needs of all people who use the service

- At Meadowfields hospital and Oakland's acute care centre we saw that information leaflets were available in different languages and staff told us how they were able to access interpreters if required. Each hospital had a 'Sacred Space' or multi-faith spiritual room and chaplin's trained to support people with mental health problems. The chaplin was also able to arrange for members of other faiths to visit and provide spiritual support. We saw that the weekly menus provided a choice of food which met the dietary requirements of religious and ethnic groups. Staff confirmed that special diets could be catered for and gave examples of providing gluten free or halal meals.
- At Mill View hospital, the Department of Psychiatry and Woodlands Conquest hospital we saw that they had full disability access and this also extended into the garden areas. Staff respected patients' diversity and human rights. Attempts were made to meet patients' individual needs including cultural, language and religious needs. Patients were advised that representatives from different faiths could be contacted to request a visit. This was advertised in the ward information leaflet. We saw up to date and relevant information boards on the wards detailing information which included: information on mental health problems and available treatment options, local services for example on benefits advice or housing, help-lines, legal advice, advocacy services and how to raise a concern or make a complaint. A choice of meals was available. A varied menu enabled patients with particular dietary needs or preferences to eat appropriate meals. Drinks and snacks could be accessed over a 24 hour period.

Requires Improvement

Are services responsive to people's needs?

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

- At Langley Green hospital each of the rooms had a bedroom that was suitable for patients in a wheelchair, or who needed extra physical support such as with adjustable beds. There was a disabled toilet and bathroom on each ward. There was information on display, and leaflets available, on all the wards, and in the hospital corridors. The included information in different languages, and in large print. There was a pharmacy information board that contained information about medication, and pharmacy education sessions that gave patients the opportunity to discuss their medication. Information was also provided about access to advocacy, how to make a complaint, and the role of and how to access the Patient Advice and Liaison Service (PALS). There was access to an external interpreting service, but this could only be booked twice a week. At the time of our inspection there was one patient in the service who required an interpreter. There was information on display about how to access spiritual support from the hospital chaplain service, and representatives of different religions. There was space available on the unit for private prayer.

Listening to and learning from concerns and complaints

- The patients we spoke with all knew their rights and how to raise a complaint. Details on how to make a complaint was included in the 'Welcome' handbook given to each patient on admission. We saw there were also information leaflets available on the wards about making complaints. The Trusts' website included information on the Patient Advice and Liaison Service (PALS) which supported patients in raising concerns.
- We saw that regular community meetings were held on each of the wards and this was an added opportunity for patients to raise concerns. Patients told us they were listened to and gave examples where they had made a complaint and positive action was taken. Staff told us that most issues were resolved informally and these concerns were not documented.
- The trust data indicated that the number of complaints increased during 2013/2014 although the proportion of upheld complaints decreased. The trust stated that following a merger of its complaints function with the Patient Advisory and Liaison Service (PALS) the numbers of complaints received were now recorded together and may provide a misleading picture in comparison with other Trusts. The most common complaint themes included; clinical treatment, staff attitude and communication.
- The staff we spoke with at Meadowfields hospital and Oakland's centre for acute care told us that they rarely received feedback from complaints. There was little analysis of themes or trends at ward level. We saw the monthly information received by the ward managers and this related to the timeliness of their response to the complaint and did not include feedback about the type of complaint, identify themes, details of any investigation or outcomes for both patients and staff.
- We saw that 'Report and learn' bulletins were sent to staff giving information about some of the complaints but this was general in nature and appeared sometime after the event.

Mill view Hospital- Psychiatric intensive care unit

Access, discharge and bed management:

- Pavilion ward was at full capacity when we inspected.
- We noted an average length of stay on Pavilion ward was between 20 to 30 days and that this was closely audited and continued on a downwards trend.
- We saw that Pavilion ward used a zoning assessment method to review all patients daily with a view to assessing ability to move through and discharge from the ward at the earliest possible opportunity.
- We saw that Pavilion ward staff were responsible for managing demand for all male PICU admissions across the trust. We looked at the PICU screening tool which assisted the overall good bed management of the ward.
- We heard from the manager that delays with discharge can occur whilst waiting for a step down acute ward bed however this is closely monitored in the twice weekly Mill View bed management meeting.
- We saw evidence that every patient on Pavilion ward would receive a number of escorted leave episodes prior to being discharged from the ward.
- We attended a Mill View bed management meeting which was held twice weekly with both inpatient and community teams to monitor and track appropriate bed usage and to identify pressures on the system.

Requires Improvement

Are services responsive to people's needs?

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

- We noted at the time of our inspection there were three patients in extra contractual, out of area admissions and four patients experiencing a delayed discharge from Mill View hospital.
- We found the bed management meeting also monitored all actual and potential inpatient delayed discharges. Resources were then deployed to assist in discharging patients in a timely manner to suit clinical need.
- We interviewed the Mill View bed manager who oversaw the system and monitored processes and appropriate admission criteria.
- We interviewed the Mill View unit Co-ordinator who also advised on best use of resources including bed usage.

The ward optimises recovery, comfort and dignity:

- Pavilion ward had a full range of rooms and equipment available including spaces for therapeutic activities and treatment.
- We looked at the, "Welcome space" of the ward. A pleasant sitting area with a,"Hot news" information board for visitors. We saw here that the carers champion details were advertised as well as some feedback from families. There were lockers available for visitors to store their personal belongings and any contraband items such as mobile phones, cigarettes and lighters. We saw clear guidance and justifications listed about the security measures taken on the ward, including contraband items.
- There were quiet rooms available where patients could meet visitors. We looked at the, "Blue room" which was a quiet TV lounge area. We also viewed the extra care, "Calm room" which was in the process of being upgraded with the advice of patients and a service user consultant.
- Patients were able to make a phone call privately.
- There was direct access to a large garden area.
- The food quality was good and a range of food and beverages were available over a 24 hour period.
- Patients were able to store their possessions securely in their bedrooms and had access to their rooms at any time they wished. All viewing panels in bedrooms were kept closed unless a patient specifically requested otherwise.
- Daily and weekly activities were advertised and available on the ward. The activities were varied, recovery focussed and aimed to motivate patients. We saw that the activities programme covered the weekend periods.
- We saw that the ward had carried out a series of focus groups with patients to ascertain their interests in developing the ward activity schedule.
- An occupational therapist was available on a full time basis and an art psychotherapy session was taking place at the time of our inspection. We saw that Pavilion ward operated a recovery star model which focussed on a holistic, person centred and recovery based approach.
- We saw that patients also had access to a recovery college.

Meeting the needs of all people who use the service:

- We noted that Pavilion ward had full disability access and this also extended into the garden area.
- Staff respected patients' diversity and human rights. Attempts were made to meet patients' individual needs including cultural, language and religious needs. Patients were advised that representatives from different faiths could be contacted to request a visit. This was advertised in the ward information leaflet.
- We saw up to date and relevant information and quality boards on the ward detailing information which included: information on mental health problems and available treatment options, local services for example on benefits advice or housing, help-lines, legal advice, advocacy services and how to raise a concern or make a complaint.
- A choice of meals was available. A varied menu enabled patients with particular dietary needs or preferences to eat appropriate meals. Drinks and snacks could be accessed over a 24 hour period.
- All patients had access to their bedroom areas, at any time of their choice, using their own swipe cards to ensure security when out of their rooms.

Listening to and learning from concerns and complaints:

- Copies of the complaints process were displayed in the ward and in the ward information leaflet.

Requires Improvement

Are services responsive to people's needs?

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

- Staff were able to describe the complaints process and how they would handle any complaints
- Staff met regularly to discuss learning from complaints. This was being used to inform the programme of improvements, including the need for staff to communicate clearly with families and carers.

Are services well-led?

Requires Improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- In 2013 the trust held focus groups with staff who informed them the trust's values and vision were unclear. Following this the trust started an initiative to promote their business objectives through publications, and leadership development initiatives.
- At Meadowfields hospital and Oakland's centre for acute care we found that those staff we spoke with were not all aware of the trust's vision and strategy; however they all aspired to provide high quality care for the patients in their care. We spoke with managers, who were undertaking the leadership programme.These staff were aware of the trust's objectives. Staff spoke highly of their individual teams and the support they got from their colleagues. Staff we spoke with told us that members of the senior management team and executive members of the trust board had visited their service.
- At Mill View hospital the trust's vision and strategies for the service were evident and on display in the wards. Staff on the wards considered they understood the vision and direction of the trust. The ward managers had regular contact with the matron and general manager. The senior management and clinical team were highly visible and we were told by staff that they often visited the ward.
- At the remaining wards and sites, most staff considered they understood the vision and direction of the trust. Most found their immediate managers visible and supportive. Some staff commented on how remote they felt the trust very senior management team was.

Good governance

- We found several areas of concern related to poor practice at Meadowfield hospital and the Oakland's centre for acute care. We found the majority of these concerns were concentrated on Maple and Oaklands wards. These two wards provided services for 33 beds out of a total of 246 acute and PICU beds, in 14 wards, across six hospital sites for adults of working age. We found, on the majority of the other wards, areas of good and also outstanding practice. Due to our concerns on Maple and Oaklands wards we were unable to rate the well-led domain, proportionately, any higher than requiring improvement.
- The trust's own governance arrangements had identified the majority of issues found at inspection and had action plans in place to address the issues. For example the trust had identified the detrimental effect the 12 hour shift pattern (with the exception of Mill View hospital) had had on staff training, support and supervision and had plans in place to revert to a three shift system as soon as possible. We saw that actions had been taken such as recruiting additional staff to the ward vacancies. However, we noted that although staff supervision, appraisals and training had been flagged as a risk, resources had not been allocated to mitigate the effect of the 12 hour shift pattern and allow staff to attend training, for example.
- At Mill View hospital, not all mandatory for all staff was up to date. The ward managers told us this was a priority area for action. The new starter induction programme had been increased from one day to two in order for all new staff to start work with mandatory training up to date. All staff received regular supervision and a yearly appraisal. In addition all staff participated in group reflective practice sessions facilitated by either the team psychologist or art therapist.
- The trust's governance arrangements had identified issues with data collection and processing of incidents however we identified that staff were not always recording all incidents as required in the trusts' incident policies.
- There were mechanisms to learn from incidents, complaints and patient feedback such as the trust bulletins and information on notice boards. However some staff, on some of the wards, told us this information was often passed on some time after the events in question and they rarely received direct

Are services well-led?

Requires Improvement

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feedback from any incident they reported or were involved in. This feedback was predominantly from Meadowfields hospital, Oakland's acute care centre and Langley Green hospital.

- Managers told us of the various meetings and groups they attended to monitor the local risks both within the trust and the wider community. For example the Western Interface meeting where current issues were discussed with the local NHS trust, the leadership team meetings where all the heads of departments met to discuss risk management and the A&E liaison group. The reports from these meetings fed into the divisional leadership meetings and from there to the trust board.
- The trust identified six 'Extreme' risks. These included improving services for people that used mental health services, maintaining financial performance, meeting contracted levels of performance, improving satisfaction with premises, reduce backlog of maintenance and reducing agency staff. Control measures were in place for each risk however there were no timescales identified.
- The trust acknowledged that the outdated information technology system had impacted negatively on the quality of information available. A recent staff survey also identified outdated information technology as a key concern.
- We were told of the trust's plan to undertake a large scale modernisation of their information technology infrastructure during 2015.
- In each of the wards we visited we found the ward managers had sufficient authority and autonomy to effectively manage their service. All managers said they felt very well supported by their line managers.

Leadership, morale and staff engagement

- Managers at Meadowfield hospital and Oakland's centre for acute care confirmed that there were some sickness and absence issues which had a knock on effect with the staff covering becoming exhausted. They told us that this was exacerbated by the 12 hour shift pattern and they were working to implement the new system as soon as possible.
- At Mill View hospital we found the wards were well-led. There was evidence of clear leadership at a local level. The ward managers were visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture on the wards was open and encouraged staff to bring forward ideas for improving care. The ward staff we spoke with were enthusiastic and engaged with developments on the ward. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line manager. Some staff gave us examples of when they had spoken out with concerns about the care of people and said this had been received positively as a constructive challenge to ward practice. Staff told us that, following improvements in the recruitment process and significant recruitment into substantive posts, morale in the service was now very good. Staff were kept up to date about developments in the trust through regular bulletins. Sickness and absence rates were below 3% (Divisional acute and urgent care division was 5.17%)
- Staff were aware of the whistleblowing process if they needed to use it. The staff we spoke with told us they felt able to raise concerns without fear of victimisation. They gave us examples of raising concerns with their immediate line managers and the action that was taken.
- The staff we spoke with told us they happy to work for the trust. Several members of staff had worked in their respective wards for some time and told us how much they enjoyed their job. We spoke with one new member of staff who told us that they were new to working in mental health services and their background was completely different. They told us how they never expected to feel so passionate about a job and loved coming to work every day.

Commitment to quality improvement and innovation

- All wards undertook a number of quality monitoring audits such as monthly records audits and the early warning scoring system (MEWS) audit. The managers told us that these local audits were useful in highlighting poor practice.
- Meadowfield hospital provided an electroconvulsive therapy service that was accredited by the Royal College of Psychiatrists and was rated as excellent in the 2014 review of its service. The service collected detailed

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information about the treatments offered and patient feedback. This information was collated by The Royal College of Psychiatrists and used to inform best practice nationally.

- We saw that the wards were using the NHS National Safety thermometer to record and identify safety themes.
- At Mill View hospital we saw the experience-based co-design project, using patients experience to direct environmental design of ward areas and quiet areas.
- The Mill View audit on therapeutic observation and engagement in inpatient wards.
- Langley Green hospital, Amber ward, the psychiatric intensive care unit (PICU), achieved AIMS (Accreditation for Inpatient Mental Health Services) accreditation from the Royal College of Psychiatrists in 2012.

Mill View Hospital- Psychiatric Intensive Care Unit

Vision and values:

- The trust's vision and strategies for the service were evident and on display in the ward. Staff on the ward considered they understood the vision and direction of the trust.
- The ward manager had regular contact with the matron and general manager. The senior management and clinical team were highly visible and we were told by staff that they often visited the ward.

Good governance:

- Not all mandatory for all staff was up to date. The ward managers told us this is a priority area for action. The new starter induction programme had been increased from one day to two in order for all new staff to start work with mandatory training up to date.
- All staff received regular supervision and a yearly appraisal. In addition all staff participated in group reflective practice sessions facilitated by either the team psychologist or art therapist.
- The ward manager told us that he is able to operate autonomously in managing the wards and received adequate support from the matron and general manager.

Leadership, morale and staff engagement:

- We found the ward was well-led. There was evidence of clear leadership at a local level. The ward manager was visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture on the ward was open and encouraged staff to bring forward ideas for improving care.
- The ward staff we spoke with were enthusiastic and engaged with developments on the ward. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line manager. Some staff gave us examples of when they had spoken out with concerns about the care of people and said this had been received positively as a constructive challenge to ward practice.
- Staff told us that, following improvements in the recruitment process and significant recruitment into substantive posts, morale in the service was now very good. Staff were kept up to date about developments in the trust through regular bulletins.
- Sickness and absence rates were 8% (Divisional acute and urgent care 5.17%)
- At the time of our inspection there were no grievance procedures being pursued within the ward, and there were no allegations of bullying or harassment.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation:

- Reduction in use of seclusion from 2011-2014. Appointed by the Department of Health as positive and pro-active champions.
- Pavilion PICU development program for all new staff.
- Experience-based co-design project at Mill View hospital using patients to direct environmental design of ward areas and quiet areas which included the re-design of the extra-care, "Calm room".
- Pavilion ward had been accredited and was a member of the National Association of Psychiatric Intensive Care units (NAPICU).

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- Pavilion ward had obtained the Royal College of Psychiatry accreditation for inpatient mental health services (AIMS).
- Pavilion ward had held a series of focus groups with patients to inform the available activity schedules.
- Pavilion ward student nurse placement initiative shortlisted for the Nursing Times student placement of the month award.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Safe care and treatment** **The trust had not protected service users against the risks associated with unsafe use and management of medicines.** • On Oaklands ward we found patients' prescription- only drugs were not held securely; • On Maple ward patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation. • On Oaklands ward a detained patient had been administered medication without lawful authority for ten days. **This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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 **The trust must have suitable arrangements in place to ensure that persons employed receive appropriate training, professional development, supervision and appraisal to enable them to deliver care and treatment to service users safely and to an appropriate standard.** • Staff had not received mandatory training within the timescales set by the trust.

Requirement notices

- Staff had not received supervision, appraisals or undertaken reflective practice in line with the trust's policy.

This was in breach of Regulation 23(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA (RA) Regulations 2014 Need for consent The trust must have suitable arrangements in place for obtaining consent and acting in accordance with the consent of service users in relation to the care and treatment provided for them. • On Oakland's ward we found patients who were not detained were prevented from leaving the ward for 24 hours or longer. There was no information available to support patients had consented to this arrangement. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 At Langley Green hospital the service must improve the recording and analysis of incidents and complaints, and how lessons are learnt from this. This was in breach of Regulation 10 (1)(a)(2)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requirement notices

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 10 HSCA (RA) Regulations 2014 Dignity and respect Wards did not always comply with the Department of Health gender separation requirements. For example at Meadowfield hospital and Oaklands ward, female only lounges were locked. All three wards were mixed gender and although they attempted to separate the genders into different corridors, depending on the gender of the patients admitted, this was not always possible. Not all bedrooms were ensuite and on Oaklands ward female patients had to pass a male area to access toilet and bathroom facilities. On Heathfields ward at the Department of Psychiatry we were concerned that male patients were required to walk through female areas to access bathrooms. In addition, there was one assisted bathroom situated in the male area and this was used by female patients if needed. This was in breach of Regulation 17(1)(a)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.