Essex Partnership University NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1LY3	Heath Close	Byron Court	CM12 9NW

This report describes our judgement of the quality of care provided within this core service by Essex Partnership University 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 Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of Essex Partnership University NHS Foundation Trust.

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We carried out a focused inspection at Byron Court due to concerns received by the CQC about the environment and the management of patients. We found the following issues that the trust needs to improve:

- The trust did not have an effective system to identify and respond to risks posed by the ward environment. The wards contained fixtures that patients might have used as ligature anchor points. Also, maintenance work was not always of a high standard. For example, there were exposed screws that might have endangered patients.
- The ward environment was sparsely decorated, with marks on walls in areas. There was a lack of robust furniture. Some patients did not have curtains or wardrobes in their rooms.
- Trust audit systems to identify ligature risks for the service were not fully effective as some ligature points were not detailed on them.
- Staff used a room to seclude patients that did not meet the Mental Health Act Code of Practice standards.
- Patients did not have identified positive behavioural support plans (or equivalent) as identified in Department of Health policy to assist staff to manage patients with complex behaviours.
- Trust data showed that the number of times that staff used physical restraint to control patients' behaviour had increased substantially in 2016/17.
- Carers told us that staff's communication with them could be improved and they were not always made to feel welcome when they visited.

However:

- Patients gave examples of how staff helped them, for example with their physical health needs and to manage daily living skills.
- Staff said there was good team working and they felt supported by their manager. Most staff were passionate about their work.
- Byron Court was accredited with the 'Quality Network for Inpatient Learning Disability Services' with an 'excellent' rating.
- The trust had identified that more nursing staff were needed to meet the current needs of patients. A senior manager had completed a nursing establishment review report July 2017 with a bid to request additional staffing. A new manager had just started in post.
- Staff were developing a training package for other service staff to increase their awareness of how best to work with patients.

Summary of findings

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

Are services safe?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the trust needs to improve:

- The trust did not have an effective system to identify and respond to risks posed by the ward environment. The wards contained fixtures that patients might have used as ligature anchor points. Also, maintenance work was not always of a high standard. For example, there were exposed screws that might have endangered patients.
- Staff used a room to seclude patients that did not meet the Mental Health Act Code of Practice standards.
- Patients had limited bedroom furniture. Staff showed us two bedroom radiators and said they had been urinated on previously by a patient. There was a distinct odour. The radiators could not be easily cleaned due to their structure and protective covering, which posed a risk of infection. Staff did not provide robust furniture for patients.
- The visitors' and activities rooms, in contrast, held a range of items which staff were not aware of and could present a risk to a patient at risk of self-harm or aggression.
- Trust data showed that the number of times that staff used physical restraint to control patients' behaviour had increased substantially in 2016/17. Three staff had been injured during incidents where patients were aggressive. Patients did not have identified positive behavioural support plans (or equivalent) as identified in Department of Health policy to assist staff to manage patients with complex behaviours.

However:

- The trust had identified that more nursing staff were needed to meet the current needs of patients. A senior manager had completed a nursing establishment review report in July 2017 with a bid to request additional staffing.
- Information from the trust stated that in July 2017, 95% of staff had completed mandatory training above the trust standard of 90%.

Are services effective?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following areas of good practice:

Summary of findings

- Patients had care and treatment plans. Speech and language therapy staff had developed easy read information for patients which detailed the best way staff should communicate with them. Patients at risk of choking had identified 'soft' or 'mashed' diets following assessment.
- Staff used recognised rating scales to assess and record outcomes for example the model of creative ability (MOCA) tool, Activity Participation Outcome Measure (APOM) and the Health Equalities Framework (HEF) outcomes measurement for learning disabilities.
- Staff were developing a training package for other service staff to increase their awareness of how best to work with patients.

Are services caring?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following areas of good practice:

- The majority of staff's interactions with patient's were caring and respectful.
- Patients gave examples of how staff helped them, for example with their physical health needs and managing daily living skills.
- Patients could give feedback on the service at 'patient forum' meetings and morning meetings.
- Carers told us the majority of staff were caring and they were invited to attend meetings.

However:

- Carers told us that staff's communication with them could be improved and they were not always made to feel welcome when they visited.

Are services responsive to people's needs?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the trust needs to improve:

- The ward environment was sparsely decorated, with scuffs on walls in areas. Patients had limited furniture in their rooms due to the risks they posed. Five patients' bedrooms did not have curtains due to risks or choice which meant their dignity was not protected.
- Carers were unable to observe daily living in the hospital and visit the patients' lounge and bedrooms due to the risks patients posed.

Summary of findings

However:

- The ward had a chef and rotating menu. Patients gave examples of being able to have favourite foods.
- Staff gave example of effective interagency and cross service working before and during patients' admission.

Are services well-led?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the trust needs to improve:

- The trust's governance systems to identify and respond to risks for the service were not effective as we found risks relating to the environment were not responded to in a timely manner.
- Trust audit systems to identify ligature risks for the service were not fully effective.

However:

- Staff said there was good team working and they felt supported by their manager. Most staff were passionate about their work. A new manager had just started in post.
- The trust was a member of the 'Quality Network for Inpatient Learning Disability Services' and Byron Court was accredited to April 2018 given an 'excellent' rating.

Summary of findings

Information about the service

Essex Partnership University NHS Foundation Trust was formed on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust and South Essex Partnership University NHS Foundation Trust.

Essex Partnership University NHS Foundation Trust provides mental health, learning disability, substance misuse, community health, GP, prison and social care services for over 2.5 million people and their families in Essex, Southend, Thurrock, Luton and Bedfordshire. The trust also has an urgent care service at Whipps Cross hospital, East London. The chief executive is Sally Morris.

The trust is registered with the CQC for 28 locations.

Heath Close is in Billericay, Essex and is registered for the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury

Byron Court is a 12 bedded unit at Heath Close. In addition to seven commissioned beds, five were available for spot purchase by commissioners. It is a mixed sex ward for patients aged over 18 years with learning difficulties or autistic disorder. It provides a service for informal/voluntary patients and patients detained under the Mental Health Act 1983.

This location was last inspected in June 2015 as part of the comprehensive inspection of South Essex Partnership University NHS Foundation Trust.

The core service was previously rated overall as 'good' with 'requires improvement' for the safe domain. A breach of regulation 13, safeguarding service users from abuse and improper treatment was identified. The trust sent us an action plan following this. There was no breach of this regulation identified at this inspection in 2017.

Our inspection team

Our inspection team was led by:

Team Leader: Victoria Green, inspection manager, mental health CQC

Lead Inspector: Kiran Williams, inspector, mental health CQC

The team that inspected this location included an inspection manager, inspector and a nurse specialist advisor.

Why we carried out this inspection

This was an unannounced inspection to this location. Our monitoring highlighted concerns and we decided to carry out a focused inspection to examine these. These included concerns about the maintenance of the ward environment and staff's management of patients.

We have reported in each of the five domains safe, effective, caring, responsive and well led. As this was a focused inspection we focused on specific key lines of enquiry in line with concerns raised with us. Therefore our report does not include all the headings and information usually found in a comprehensive inspection report.

Summary of findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the trust.

We carried out an unannounced visit on 27 July 2017. During the visit we

- visited the ward
- spoke with three patients using the service
- spoke with three carers or relatives of patients
- spoke with five staff members; including nursing staff, occupational therapy staff and a student nurse
- spoke with the ward manager and associate director for learning disability
- reviewed care and treatment records relating to three patients
- observed a ward handover
- observed how staff were caring for people
- reviewed two staff records
- reviewed information we had asked the trust to provide
- reviewed a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

- Patients gave examples of how they were involved in their care and how staff helped them, for example with their physical health needs and managing daily living skills such as cooking, cleaning and laundry.
- Patients said they could eat their favourite foods at times in hospital. A patient said staff encouraged healthy eating.
- Patients we spoke with had a clear understanding of their care and discharge pathway.
- Carers said they were invited to attend multi-disciplinary meetings to discuss the patient's care and most staff were caring. However, they said that staff's communication with them could be improved and they were not always made to feel welcome when they visited.

Areas for improvement

Action the provider MUST take to improve

- The trust must review its governance systems for assessing and monitoring the quality of ward environments.
- The trust must ensure ward maintenance actions are completed.
- The trust must review their processes for ligature assessments and ensure ligature risks are removed.
- The trust must ensure the ward has safe furniture and furnishings for patients which promote a recovery environment.
- The trust must ensure that the room used for seclusion is fit for purpose.
- The trust must review its assessment and care planning process for restrictive practices.
- The trust must ensure that patients privacy is protected.

Action the provider SHOULD take to improve

- The trust should ensure staffing levels are adequate to meet patients' needs.
- The trust should review its arrangements for visitors' access to the ward.

Are services safe?

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

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

Our findings

Safe and clean environment

- The layout of the ward meant that staff could observe patients appropriately. There were separated parts of the ward day area, bedrooms and activity rooms.
- Staff said the ward was now not suitable for patient's needs. We found environmental issues which posed a risk to patients' safety including ligature points, such as high level door closers, door hinges, unfixed pictures mid-level soap dispensers, window handles and sink taps and low level toilet seats. These were identified at our previous Mental Health Act reviewer visit in August 2016. The provider sent us a statement November 2016 detailing that audit of ligature points would be completed and the trust's health and safety department would risk assess the environment.
- Staff reviewed the ligature audit on 07 March 2017 but it did not capture all risks for example, pipes in the activities kitchen and also an assisted bathroom and bedroom. Therefore the process for staff to manage and reduce the risks of these was not identified.
- Three soap dispensers had been removed to prevent risks to patients. However, some fittings still remained such as a screw in one bathroom which could pose a risk to patients. The ward had damaged walls, doors and furniture. Some chair backs were removed from fixed dining room furniture. Three plug sockets were damaged and loose. Staff said they had isolated the electricity to these areas. Staff were visiting other wards to look at more robust furniture and furnishings.
- The ward had cleaning staff who were present when we visited. However, radiator covers were not easy to clean and two radiators were identified as not hygienic due to patient damage and rust. A patient said their radiator was broken. Staff said they had reported for repair. The trust stated it was not broken but dented. There were stains and marks on a corridor wall and the lounge ceiling where fluids had been thrown.
- The ward did not have a purpose built seclusion room. Instead staff had changed the lock on a bedroom to be able to lock a patient inside if required. Staff said it had been used in the last year. The room did not meet the standards outlined in the Mental Health Act Code of Practice, such as it did not give clear observation, two-way communication, and secure furnishings. Therefore there could be risks to patients and staff if used to manage a patient with aggressive behaviour.
- In contrast to the sparseness of bedrooms and the ward lounge, the visitor's room and activities rooms outside the main ward area held a range of items which held items staff were not aware of and had risk assessed. These could present a risk to a patient at risk of self-harm or aggression. For example unlocked drawers with items, such as CDs, computer cables, craft and music equipment. Staff said they would not leave patients alone in these rooms.
- The housekeeper was reviewing the amount of staff keys and alarms, as some were damaged during incidents and at times there were not enough.
- The ward had identified bedrooms for men and women with ensuite bathrooms. A quiet room was identified as female lounge. There were a 'swing corridor bedrooms' which could be used flexibly to accommodate ward needs.

Safe staffing

- The trust had identified the nursing staff establishment for the ward as 6.7 whole time equivalent (wte) nurses and 8.49 wte healthcare assistants, plus a manager post.
- The nursing shift pattern was one nurse and two healthcare assistants during day shifts and, one nurse and one healthcare assistant at night. However, staff told us that due to a change in patients' presentation over the last three years and the fact that ward was isolated (the nearest ward was six miles away) this was not enough and more staff were needed. A member of staff worked a 'twilight shift' from 16:00 to 24:00 hours to support patient's bedtime routines. The ward manager said they ensured two nurses were on shift at night to give support. However, the trust stated this was incorrect and three staff, a nurse and two support workers were on duty at night.
- A senior manager had completed a nursing establishment review in July 2017 with a bid to request additional staffing. During our visit, all patients were on 1:1 observations with staff being in eyesight of them and managers requested additional staff for this.

Are services safe?

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

- There were three nurse and no healthcare assistant vacancies. Regular bank (used as and when required) staff were used for the additional cover. Two band five nurses had been recruited and were due to start employment in September 2017.
- Trust 'safer staffing' data showed for July 2017 100% of staff shifts were filled in the afternoons with 91% qualified and 97% unqualified staffing morning shifts filled. Data for June 'staffing shift rates were over 90% in the morning and 100% or more in the afternoon. Trust information for May 2017 showed 14% staff vacancies, with 54% bank staff usage and 5% agency staff usage.
- Staff said they were encouraged to report when low on staff as an incident. Trust information showed only one reported incident from April to May 2017.
- However, staff gave a range of examples of how insufficient staffing had impacted on the service. These included nursing staff not being able to provide activities at weekends, not being able to provide staff escorts for patients on leave, affecting staff's ability to carry out restraint (this risk was reduced as managers booked bank staff); other nursing's interventions being missed such as physical healthcare, and fluid diet charts not fully completed. Carers said that non-permanent staff did not always know how best to support patients.
- The ward had access to three consultant psychiatrists who covered four geographical areas. Staff accessed medical cover via an on call system. One consultant was based at the hospital location. There was an out of hours on call rota for staff to contact senior managers.
- Information from the trust stated that in July 2017, 95% of staff had completed mandatory training above the trust standard of 90%.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment for patients within 72 hours of admission and updated this as needs changed.
- There were policies and procedures for use of staff observation of patients. Staff reviewed patients' observations daily. Although at our visit all staff told us that patients present on the ward were on 1:1 observations within staff eyesight due to risks they posed to themselves or others. The trust stated that this information was incorrect and all patients on the ward the day of our visit were in staff eyesight due to the activities on the ward. Therefore were not assured that all staff were aware of the level of observations patients required.
- Staff said they were admitting more patients with complex behaviour and an increased risk of self-harm or aggression. Staff said restraint was only used after de-escalation had failed.They said the day we visited was reasonably settled. During our visit an incident of patient aggression to staff occurred. A trust report July 2017 confirmed that patients' needs had changed over the two to three years with increased levels of violence and aggression requiring more nursing interventions such as restraint and observation. Trust information showed 26 incidents of physical assault from April to May 2017. A trust report July 2017 identified most incidents were in the daytime. Three staff injuries had been reported to the health and safety executive.
- Trust information showed 224 incidents of restraint from April 2016 to March 2017, a notable increase since the previous year with 65 incidents. The trust stated the increase was due to a patient whose behaviour was challenging because of their illness.Latest trust data for April and May 2017 showed 25 incidents. None were identified as prone restraints.
- Staff had not created a behaviour support plan (or equivalent) following recent assessment of the person's behaviour, which staff acknowledged. The Department of Health policy document 'Positive and Proactive Care' April 2014 references individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.
- However, staff said a behavioural therapist was in post and reviewed 'ABC', antecedent behaviour and consequence records staff completed to track triggers for patient incidents. However, a staff member said there could be challenges with getting staff to complete these regularly. For one patient, staff had compiled a document 'all about me' which included early warning signs and details of how best to support the patient. Staff told us these were usually developed with patients after they had been in hospital for a while. Not all patients had them as yet. Carers for one patient said that more emphasis could be given towards talking therapy.

Are services safe?

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

- Staff told us there was staff training planned for this in September and staff were looking to develop separate de-escalation plans. The ward manager was a restraint techniques trainer and trust training was changing over to a new approach.
- Trust information showed no seclusion or long term segregation of patients for April or May 2017 and five incidents for April 2016 to March 2017. The room identified for seclusion room was last used 27 June 2017. The nearest purpose built room was approximately six miles away in Basildon and staff would need to request secure transport and arrange for escorts to safely transport a patient. Managers were developing a plan to give to the trust for August 2017 to have a de-escalation and purpose built seclusion room. At our visit a patient was in the bedroom previously used for seclusion. We saw they were able to move about the ward.
- A January 2017 record for a patient nursed in long term segregation showed there was no nursing review and medical review on the day of seclusion. Staff told us the patient was at that point transferred to another ward. Following our last inspection the trust at that time sent the CQC an action plan which stated monitoring forms would be completed following an incident of seclusion or long term segregation. This trust clarified that this form had not been completed for the latest seclusion incident in June 2017. However, there were not any identified issues following their check on this. The trust stated all qualified staff would be reminded of the need to complete this form at the next team meeting in August 2017.
- Staff received safeguarding training which included being mindful of personal boundaries with patients. A patient and a carer told us of an incident and the trust gave an update on the management of these. The trust safeguarding team were working with staff to increase their reporting of incidents and contacting them for advice.
- We observed a ward staff shift handover meeting and saw documentation staff used to structure the meeting. Staff appropriately discussed risks and incidents as relevant for patients.
- As this was a focused inspection we did not check the clinic room or review management of medication practices. During our visit a pharmacist visited and staff reported they had received verbal feedback that the controlled drugs audit showed an improvement on the last three months. Staff said they had regular pharmacy support such as monthly visits and weekly telephone contact.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Patients had care and treatment plans. Staff supported patients to access annual health assessments. The trust had a health facilitation team which followed up on patients' physical health checks. However, there were no specific health action plans.
- Patients had individualised activity programmes based on assessed level of need.
- Staff used the trust's electronic patient record system for recording information. We noted some staff having difficulties with slow systems and on one occasion we also had difficulties accessing information. We found old computer disks in a room used for visits and meetings believed to belong to former patients. Staff were unsure what information was kept on there and said this would be investigated.

Best practice in treatment and care

- Since our last inspection staff reported an increase in accessing psychology team support.
- The ward had behavioural therapy and speech and language therapy staff who carried out specific assessments.
- Patients at risk of choking had identified 'soft' or 'mashed' diets in place. The chef said they had guidance from the speech and language therapist on how to prepare these meals for patients. Patients had protected mealtimes to support patients as required with eating or drinking. A patient said staff encouraged healthy eating. However, carers said staff they were not aware of this.
- Staff developed easy read information for patients such as for advanced directives, 'my choices' and dysphasia. Staff used a document 'all about me' with patients which detailed the best way staff should communicate with them. Other examples of developments were social stories and medication plans.
- Staff use recognised rating scales to assess and record outcomes for example the model of creative ability (MOCA) tool, activity participation outcome measure (APOM) and the health equalities framework (HEF) outcomes measurement for learning disabilities.
- Staff gave examples of audits completed for the ward such as for care plans.

Skilled staff to deliver care

- The ward had access to occupational therapy and physiotherapy staff.
- Staff said bank staff workers were given supervision and invited to unit training sessions. New staff had an induction.
- There was no specific mandatory training for working with patients with a learning disability or autism or challenging behaviour. Nurses said they were trained to work with patients with a learning disability. Examples of specialist training included and sensory awareness. The psychology team were offering autism training in September. A senior occupational therapist had completed sensory integration training.
- A manager said they had completed a training needs analysis and were developing a formal training package.
- Trust information showed 94% staff had appraisals in the last year May 2017 and 76% of staff were supervised in last six weeks. This was below the trust standard of 90%. Staff acknowledged this had not happened consistently.
- Monthly team meetings took place for staff to share information.

Multi-disciplinary and inter-agency team work

- The ward had weekly medical reviews. Additionally multi-disciplinary team meetings took place where community patients and inpatients were discussed along with referrals.
- Staff discussed patients' needs such as patients food and drink intake at handover meetings. Managers attended these meetings. Staff informed us of a recent internal compliance visit on 20 July 2017 which had given positive comments about the handovers delivery.
- Staff had working relationships with other teams in the organisation. Some staff such as an occupational therapist worked also in the community teams and this was useful for communication. Some community staff were based at the same location as the ward.
- Staff were developing a training package for other service staff to increase their awareness of how best to work with patients. They planned to identify champions for learning disability within services.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- The majority of interactions from staff with patients were caring and respectful. We observed on one occasion when a staff member was abrupt with a patient. Staff said they often knew patients well as they had been previously admitted.
- Patients gave examples of how staff helped them, for example with their physical health needs and managing daily living skills such as cooking, cleaning and laundry.
- Carers told us that the majority of staff were caring. However, they said that staff's communication with them could be improved. Examples included, staff not telephoning them back to give an update when they said they would and staff not having a consistent approach. Carers said they could not always understand what some staff were saying to them because of staff's accent or at times some staff could be abrupt. Carers said they were not welcomed when they visited and one said at times were left waiting for meetings. They said staff could give more support to patients to attend to their personal hygiene. During our visit patients appeared to have been supported with this.

The involvement of people in the care that they receive

- Staff involved patients in decisions about their care.
- Carers said they were invited to attend multi-disciplinary meetings. One said staff offered telephone conferencing if they could not travel to meetings. Staff asked them for their views on the care.
- Staff and a carer said patients were offered easy read version care plans.
- Patients had access to independent advocates.
- Patients could give feedback on the service at 'patient forum' meetings and morning meetings such giving their views and making choices about daily activities menu, individual time with staff and menus.
- Patients were invited to be involved in recent staff recruitment.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- Trust information for May 2017 showed the average bed occupancy was 62%. Prior to patient's admission a telephone conference call was held with the multi-disciplinary team the commissioner and social care staff and not all patients were admitted.
- The manager said the average length of stay was approximately three months. Trust data showed the ward had no more than seven patients since 01 May 2017 to July 2017.
- The ward provided a service for South Essex, Southend and Thurrock. In addition to seven commissioned beds, five were available for spot purchase by commissioners. There were six patients on the ward at our visit.
- If a patient needed a higher level of care then a psychiatric intensive care unit could be accessed locally.
- The ward usually admitted patients from age 18 years and above. However, in the last year a younger person aged 17 years had been admitted. Staff stated that older people could be admitted to the ward but this was not usual.There had been a recent example where a patient had a delayed discharge whilst an alternative placement was sought. Staff said there had been an increase in patients being admitted with a borderline learning disability and mental health needs, who needed different care and treatment. Two carers said the placement had not met their relative's needs but they had not raised any complaint with the service.
- Patients we spoke with had a clear understanding of their care and discharge pathway. Staff said within two weeks a care and treatment review took place with commissioners and discharge planning was considered at the start of a patient's admission. Commissioners would get weekly reports with updates on patients. Discharge plans were discussed at weekly reviews. Carers gave examples of being involved in discharge planning.
- There were no reported delayed transfers of care in the last three months. Staff said there could be delays with funding or appropriate community placements being available.
- The service worked closely with the intensive support team for learning disability and mental health who provided community support as an alternative to admission in the unit.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a range of rooms to support treatment and care such as an activity room and an activities kitchen (separate from the main kitchen).
- The ward had an identified room for visits outside the patients' main living space. Staff said they did not usually allow carers to visit the patients' lounge and bedrooms due to the risks patients posed. One carer expressed concern at this and said they had asked to see the areas but were told they could not. This meant carers were unable to observe daily living in the hospital.
- Staff said the telephone had been damaged by a patient. Meanwhile patients could either access their own mobile phone or the staff telephone for private calls.
- Patients had access to outside space and gardens. During our visit a scheduled pet therapy session took place in the garden. A patient told us they were going on leave that day into the community for a shopping trip. Staff said they would take patients to local community groups and activities such as cycling. Carers told us they did not believe patients had enough structure in their day which included activities.
- The ward had a chef and rotating menu. Patients gave examples of being able to have favourite foods. The area for patients to have drinks and make snacks was restricted due to the risk patients posed. Patients could access the activities kitchen to make breakfast.
- However, staff said the current ward environment was not suitable for patients. The main patient's area was sparsely decorated, with scuffs on walls in areas. The sparseness and the lack of furniture caused sound to echo which would not be suitable for patients with hearing sensory needs. There was little evidence of patients being able to personalise their bedrooms. However, two patients told us their preference was to have a minimalist bedroom with minimal furniture and items and two patients had mattresses on the floor.
- Staff did not encourage patients to bring all their possessions with them on admission as there were not identified areas for storing possession securely in

rooms. Three patients did not have direct access to a wardrobe or clothing in their room due to risks they might have with furniture. A carer expressed concern that a patient was wearing the same clothes on three occasions when they saw them and staff had not arranged for them to have clothes access. Staff said that they had introduced a new system for identifying patients' clothes on admission to ensure they did not get lost.

- Five patients' bedrooms did not have curtains due to risks or patients' choice and did not have privacy film which meant their dignity was not protected if other patients were in the garden. From one bedroom we could see the road. However, activity areas did have privacy screen on windows.
- Staff said storage was inadequate and we saw examples where broken and damaged furniture by patients were stored in empty rooms whilst awaiting disposal. Broken information technology items and a drier were stored in the electrical storage cupboard.

Are services well-led?

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

Our findings

Good governance

- We had concerns about the length of time the trust had taken to address risks identified for this ward. This included the effectiveness of trust governance systems to ensure action was taken to respond to highlighted risks and give feedback to staff when they had raised concerns. The overall ward appearance indicated the current maintenance arrangements had not been sufficient.
- Staff had identified risks for the service being delivered on the ward due to a change in patients' needs and environment on the trust risk register December 2016. The trust had set up a 'task and finish group' in January 2017 to look further into these concerns. Trust staff had completed environmental risk assessments such as the 'Health, safety and security workplace inspection' in January 2017. Health and safety meeting minutes seen from January 2017 did not consistently capture the review of these risks and actions taken to address them. Monthly ward team meetings took place but meeting minutes showed a lack of detail of items discussed and minimal reference to environmental challenges. Staff told us that due to lack of responses by the trust estates department they had raised a complaint. The trust's head of estates and facilities had visited on 26 July 2017 to check the environment. This was seven months after the trust identified the risk on their register.
- The trust and managers had some key performance indicators to monitor and assess the quality of the service provided.
- Managers said they attended meetings to share information about the trust and their service such as the learning disability service manager group and health and safety meetings. The chief executive and executive nurse had both visited the ward since April 2017. Trust staff visited the ward on 20 July 2017 to carry out an internal compliance visit (mock CQC type visit). The report was not yet available when we visited.
- At the time of our visit a senior manager had completed plans for a business case to present in August 2017, to the board, for developing a de-escalation suite and trust investment in the ward. A senior manager had completed a nursing establishment review report in July 2017 with a bid to request additional staffing.

Leadership, morale and staff engagement

- Most staff reported being passionate about their work and committed to delivering a good service for patients and said the morale was generally good. Staff said they had felt frustrated at times due to low staffing levels.
- Staff said there was good team working and they felt supported by their manager. They said they knew how to use the whistle-blowing process and raise concerns without fear of victimisation. Most said they felt able to give feedback on the service. Managers said they have an 'open door' for staff to approach them with any concerns.
- The ward manager post had been vacant from April 2017 until July 2017. The post had been advertised but had not been recruited to. A staff member was now seconded to the role. They had opportunities for leadership training. However, due to staffing needs they were required to be on the ward and were not able to give the time they wanted to management tasks.
- Three staff said there had been a high turnover of staff leaving in the last year. However, this was not corroborated by trust data which showed, 4.78% staff turnover. May 2017 trust data showed 4.2% staff sickness, below the national average. Managers said there were systems to monitor staff performance and sickness applying trust policy and procedures.

Commitment to quality improvement and innovation

- The trust was a member of the 'Quality Network for Inpatient Learning Disability Services' and Byron Court was accredited to April 2018 given an 'excellent' rating.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured ligature risks were removed. The trust had not ensured the ward had safe furniture and furnishings for patients which promoted a recovery environment. The trust had not ensured that the room used for seclusion was fit for purpose The trust had not ensured patients had care plans for staff to follow to reduce the need for restrictive practices. This is a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust had not ensured its governance systems for assessing and monitoring the quality of ward environments were effective. The trust had not ensured ward maintenance actions were completed. This is a breach of regulation 17

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The trust had not ensured patients privacy was protected as bedroom windows were left uncovered. This is a breach of regulation 10.