St Andrews Healthcare

Services for people with learning disabilities or autism

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)
St Andrew's Healthcare	1-102643363	Hawkins Ward Mackaness Ward Harlestone Ward Ferguson Ward Bradlaugh Ward	NN1 5DG
St Andrews Healthcare Nottinghamshire	1-233736027	Thorsby Wollerton Rufford Newstead	NG18 4GW

This report describes our judgement of the quality of care provided within this core service by St Andrew's Healthcare. 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.

Summary of findings

Where applicable, we have reported on each core service provided by St Andrew's Healthcare and these are brought together to inform our overall judgement of St Andrews Healthcare.

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 Services for people with learning disabilities or autism	Requires Improvement 
Are Services for people with learning disabilities or autism safe?	**Requires Improvement** 
Are Services for people with learning disabilities or autism effective?	**Requires Improvement** 
Are Services for people with learning disabilities or autism caring?	**Requires Improvement** 
Are Services for people with learning disabilities or autism responsive?	**Requires Improvement** 
Are Services for people with learning disabilities or autism well-led?	**Requires Improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- We found that there were not always enough members of staff to care for people safely. Some staff and patients told us that they did not always feel safe on the wards.
- There were safeguarding processes in place on all wards. However some staff we spoke with could not clearly explain what a safeguarding concern was or when it would need to be escalated to external agencies.
- There were not clear systems to ensure that agency and bank staff were aware of safeguarding protection plans on the wards that they were working on.
- We were concerned that there appeared to be routine restrictive practices in place to assess and manage risk, irrespective of individual needs and risks.
- Information about the complaints process was not clearly displayed on the wards in formats people could understand.
- We found that patients told us that they did not feel that their complaints were always listened to or acted on. Patients told us that they did not get always feedback from their complaints.
- Independent investigations were undertaken if complaints were `upheld`. However, most complaints were recorded as `not upheld`, if they had been resolved at a local level. This could mean that potential themes on the wards were not investigated appropriately.
- We were concerned that the CQC have not been sent notifications relating to incidents affecting the service or the people who use it, in line with requirements of regulation 18 of the Health and Social Care Act.
- Seclusion facilities were being routinely used for de-escalation and time out and not recorded as seclusion.
- Patient care and risk was not assessed, planned and managed based on individual needs. There was an emphasis on generic, restrictive risk management processes, including restricting visitors and leave, which are not in line with current Department of Health guidance, the principles of the Mental Capacity Act or the Mental Health Act code of practice.
- Risks, benefits and alternative options of care and treatment were not discussed and explained in a way that the person who uses the service understands.
- Not all wards had resuscitation equipment. There were a number of locked doors, stairs and potentially an unpredictable patient group, which may impact how quickly the equipment arrived where it was needed

Summary of findings

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

Are services safe?
<Summary here>

Are services effective?

Requires Improvement

Due to the complex needs of the people who use the service, some elements of choice and care were legally restricted, as some were detained under the Mental Health Act. Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to assess and manage risk, irrespective of individual needs and risks.

Patients were commissioned to have a minimum of 25 hours per week of structured activity for each service user. The programme of treatment included occupational therapy and individual psychology sessions. Some staff told us that they did not think that 25 hours was achievable for some patients. Some patients did not feel they had a choice about what to attend.

There were multi-disciplinary teams (MDT) identified as part of the staffing establishment, with each team including psychiatrists, nurses, pharmacists, psychologists, occupational therapists, and social workers. Other allied professionals such as dieticians, teachers and speech and language therapists worked within the service and responded in good time to referrals. Most staff told us that the training offered by St Andrew's was excellent. We saw a comprehensive training schedule.

Are services caring?

Requires Improvement

We observed little activity or interaction between staff and patients on the wards we visited. Some patients told us that they were well cared for and they had no concerns about the staff. Some patients felt angry and frustrated by how they are treated; stating that staff do not listen to them and did not always speak to them with respect.

There was little evidence that patients or their carers were actively involved in writing or reviewing their care plans. Most patients we spoke with did not have a copy of their care plan and could not identify goals. Some patients were aware that they could request a copy.

There were some support and engagement projects with the patients on the wards provided by the patient experience team. There were patient representatives on the ward who told us they felt listened to in the meetings they attended.

Summary of findings

Are services responsive to people's needs?

Requires Improvement

Referrals and admissions were accepted from other St Andrew's services and NHS or independent healthcare providers nationally. Pathway bed management meetings took place on a weekly basis and referrals were assessed promptly. There were some patients who were not on appropriate wards for their needs.

We were told by staff and patients that staffing arrangements sometimes affected patient access to activities, outside space and leave arrangements. We saw that there were blanket restrictions in place as part of the overall ward routines.

There was a complaints procedure, although we did not observe easy read information about this clearly displayed on the wards. Patients told us that they did not feel that their complaints were always listened to or acted on.

Are services well-led?

Requires Improvement

Some staff told us that there was little engagement with senior managers or the organisation `s values. We were told that many of the governance, care and treatment processes were centrally administrated.

Most staff working directly on the wards told us that they felt stressed and did not feel valued or supported. Staff told us that it was difficult working with high numbers of bank and agency staff in very challenging environments.

Staff generally felt able to raise concerns with their immediate line manager or senior nurses. The managers we spoke with, told us that they felt that their immediate service manager was supportive and listened to concerns that they raised.

Summary of findings

Background to the service

St Andrew's Northamptonoffers medium and low secure specialist services for adults with mild/borderline learning disabilities and challenging behaviour, including individuals who may also have a mental health problem and offending history. They also have care pathways and wards specifically for adults diagnosed with autistic spectrum disorder (ASD).

The services are located at Northampton. We visited the 5 male wards located in Northampton, accepting admissions for men aged 18 to 60 years, who meet their criteria.

Hawkins Ward is a 15 bedded medium secure service for men with learning disability, and forensic and challenging behaviour.

Mackaness Ward is a 15 bedded medium secure service for men with a diagnosis of autistic spectrum disorder, who may also have associated mental health needs, challenging or offending behaviour.

Harlestone Ward is a 20 bedded low secure service for men with a diagnosis of autistic spectrum disorder, who may also have associated mental health needs, challenging or offending behaviour.

Ferguson Ward is a 16 bedded low secure unit for men with learning disability, and forensic and challenging behaviour.

Bradlaugh Ward is a 12 bedded locked rehabilitation ward for men with learning disability, and forensic and challenging behaviour.

St Andrew's Healthcare Nottinghamshire is a 66 bedded purpose built regional centre for men detained under the Mental Health Act (MHA). Patients admitted include those with a diagnosis of lower functioning autism and Asperger's syndrome; and have either established or suspected mild/borderline learning disabilities, who may present reactions to trauma and social deprivation. They may also have additional mental health needs, and a history of offending or challenging behaviour. Referrals are taken across the United Kingdom. The centre consists of four wards:-

Thorsby ward – a 14 bedded medium secure unit.

Wollerton ward – a 16 bedded medium secure unit.

Rufford ward – a 18 bedded low secure rehabilitation and recovery unit.

Newstead ward – a 16 bedded low secure assessment and treatment unit.

Our inspection team

Our inspection team was led by:

Chair: Stephen Firn, Chief Executive, Oxleas NHS Foundation Trust

Team Leader: Nicholas Smith, Head of Hospital Inspection (Mental Health)

The team who inspected learning disability was made up of a CQC inspector, CQC clinical national professional advisor for people with learning disabilities, CQC Mental Health Act reviewer, speech and language therapist, nurse, consultant psychiatrist, advocate, expert by experience and their carer.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of independent health care providers of mental health services. This provider was selected to enable the Care Quality Commission to test and evaluate its new inspection methodology across a range of different mental healthcare service providers.

Summary of findings

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 the core service and asked other organisations to share what they knew. We carried out announced visits 9 – 11 September 2014. During the visits we talked with 25 people who use services. We observed how people were being cared for and talked with 4 carers and/or family members. We spoke with 38 members of staff, including nurses, doctors, support workers, ward administrators and a range of allied health professionals, including occupational therapists, social workers and dieticians. We reviewed 10 electronic care records and 11 Mental Health Act records of people who use services.

What people who use the provider's services say

Some patients told us that they were well cared for and they had no concerns about the staff.

Some patients felt angry and frustrated by how they are treated, stating that staff do not listen to them and did not speak to them with respect.

Patients told us that the restrictions from the overarching risk safety system made them feel frustrated and angry.

Carers told us that there was limited carer support and involvement.

Good practice

We did not identify any innovative practice during this inspection.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider must ensure that information about the complaints process is clearly displayed on the wards in formats people can understand.
- The provider must improve how patient complaints are resolved and feedback given to the patient.
- The provider must ensure that independent investigations are undertaken if complaints are `upheld`. They should also review the process to ensure potential themes resulting from complaints that were "not upheld" are reviewed.
- The provider must ensure that all staff have training and understanding about safeguarding.
- The provider must ensure that agency and bank staff have adequate information about individual patient care.
- The provider must review and stop the use of seclusion facilities for de-escalation and time out.
- The provider must ensure that the CQC have been sent notifications relating to incidents affecting service or the people who use it, in line with requirements.
- The provider must ensure that care plans and risk assessments are improved to ensure people received care which is appropriate, safe and effective.
- Not all wards had resuscitation equipment. There were a number of locked doors, stairs and potentially an

unpredictable patient group, this may impact how quickly the equipment arrived where it was needed. The provider must ensure that lifesaving equipment is available without delay.

- The provider must ensure that risks, benefits and alternative options of care and treatment are discussed and explained in a way that the person who uses the service understands.
- The provider must ensure that all staff can demonstrate that they understand appropriate use of the seclusion facilities.
- The provider must ensure that staffing arrangements which have an impact on patients accessing activities, accessing the outside space and their leave arrangements are minimised.
- The provider must assess and treat patients based on individual risk and identified needs, rather than placing emphasis on generic, restrictive risk management processes.
- The provider must ensure that there are enough members of suitably skilled and experienced staff to care for people safely
- The provider must ensure that shift patterns allow for a comprehensive handover and nursing discussion.
- The provider must ensure that this process is reviewed to ensure that all care and treatment is patient centred and relevant to the patient group rather than being centrally administrated.

Action the provider SHOULD take to improve

- The provider should engage with staff to understand why morale is low and people are leaving substantive posts.
- The provider should review patients long term placement options who have been in extra care facilities for prolonged periods of time
- The provider should ensure that staff moving patients to seclusion facilities is safe
- The Provider should ensure that information is provided in formats that people understand, clearly displaying information about complaints and external agencies, such as the citizens advice bureau and CQC.
- The provider should promote better involvement of patients and their carers/family in writing and agreeing care plans and risk assessments and ensuring people have copies of these.

St Andrews Healthcare

Services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hawkins Ward Mackaness Ward Harlestone Ward Ferguson Ward Bradlaugh Ward	St Andrew's Healthcare - Northampton
Thorsby Ward Wollerton Ward Rufford Ward Newstead Ward	St Andrew's Healthcare Nottingham

Mental Health Act responsibilities

We looked at eleven records over the 5 wards, including seclusion records, on each ward. We found that the records were kept accurately and in line with the Mental Health Act code of practice.

We checked the T2 (certificate of consent to treatment) and T3 (certificate of second opinion) forms. We found that these were not always accurate. Some specified medication the person was no longer taking, or did not always represent the dosage of medication the person was taking, which was over the British National Formulary (BNF) recommended limit.

Patients we spoke with were aware of their rights. Section 17 leave and access to visitors, including solicitors, was dependant on the risk level that the patients were on within the generic risk safety system. This was not in line with code of practice Mental Health Act 1983, chapter 19, which has clear guidance regarding restriction or exclusion of visitors.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Due to the complex needs of the people who use the service, some elements of choice and care were legally restricted, as some were detained under the Mental Health Act. Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to manage risk. Some of the blanket restrictions relating to people having time off the ward and visitors were not in line with the principles of the Mental Capacity Act.

We spoke with a number of consultant psychiatrists, who demonstrated an understanding of the Mental Capacity Act. The ward social workers took a lead role in identifying when there may be indication to use deprivation of liberty safeguards.

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

Harlestone, Hawkins and Mackaness wards were newer facilities. Bradlaugh and Ferguson wards were in an older part of the hospital and were not suitable to meet patient needs. They were due to be relocated in 2015. Potential ligature points were managed as part of individual and unit risk assessments.

We observed that the wards were clean and free of odours. There was an established emergency protocol in place, which staff explained clearly to us. However, we were concerned that in the event of an emergency, there were a number of locked doors, stairs and potentially an unpredictable patient group, which may impact how quickly the equipment arrived where it was needed.

We found that there were not always enough members of staff to care for people safely. Some staff and patients told us that they did not always feel safe on the wards. There were safeguarding processes in place on all wards. Some staff we spoke with could not clearly explain what a safeguarding concern was or when it would need to be escalated to external agencies. We saw that incident reports were dealt with in line with the St Andrew's policy and recorded on an electronic reporting system. We were concerned that the CQC have not been sent notifications relating to incidents affecting the service or the people who use it, in line with requirements of regulation 18 of the Health and Social Care Act.

Our findings

Safe and clean ward environment

Harlestone, Hawkins and Mackaness wards were newer facilities. Bradlaugh and Ferguson were in older parts of the hospital. Potential ligature points were managed as part of individual and unit risk assessments. Regular ligature audits were undertaken by the central audit team and were completed 6 monthly. We saw audits had been undertaken on all wards in July 2014. There were areas with clear lines of sight which enabled staff to monitor patients who needed closer observation. Staff were allocated to work in areas of the ward where line of sight may be restricted.

We observed that the wards were clean and free of odours. Regular room audits were undertaken by the wards. The décor was quite bare and neglected, particularly on the older wards, although Harlestone and Bradlaugh wards had some artwork on the walls. We observed that all of the wards had a suitable clinic room. However, not all wards had resuscitation equipment; these were located on nearby wards. There was an established emergency protocol in place, which staff explained clearly to us. However, we were concerned that in the event of an emergency, there were a number of locked doors, stairs and potentially an unpredictable patient group, which may impact how quickly the equipment arrived where it was needed.

The seclusion facilities did not meet with the Mental Health Act code of practice minimum standards. The line of sight in the en-suite bathroom area of seclusion on Mackaness was poor, which meant patients were required to urinate in a bottle if staff felt it was not `safe enough` to enter the en-suite. Bradlaugh ward did not have seclusion facilities. Bradlaugh ward used the seclusion room on Ferguson Ward, which was downstairs from them. We were told when seclusion facilities on Ferguson Ward were in use, the wards accessed Sherwood Ward seclusion facilities. We were concerned about the safety of moving people in a restraint situation, either downstairs or using a lift, which we were told was unreliable and had broken down several times. We were concerned about patients being moved to the seclusion room on Ferguson ward also, as access to it included some steps and going through a narrowing corridor.

The wards had limited facilities for patients to raise an alarm, for example, nurse call bells in bedrooms. However, the ward staff undertook minimum hourly observations and regular safety nurse checks, an alarm could therefore be raised with a member of staff.

Requires improvement

Are services safe?

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

In Nottingham

There were systems and processes to maintain a clean environment. The service user satisfaction survey in April 2014 rated the hospital as amber for cleanliness, this means over 75% of respondents were satisfied.

Generally the wards were clean. Bed linen was changed daily. There were hand washing information on the wards and access to hand washing fluid. There were daily cleaning rotas which had been completed. In the cleaning cupboard there were colour coded mops for use in certain areas. Furniture had been selected by patients and was clean and new.

Clinic rooms were fully equipped, clean and tidy with a weekly cleaning schedule that was up-to-date.

We looked at the resuscitation equipment and found that emergency drugs were in date. The emergency bag was scheduled to be checked weekly. We found that these checks had not been completed routinely.

Resuscitation equipment was shared between wards. We were informed that this did not delay its use.

We asked to see the current environmental/ligature audits. Newstead provided a fire risk audit and environmental action log dated November 2013 the information provided did not state if actions had been completed. Staff were not clear if these were the most recent versions.

We found that bedrooms had blind spots. Staff confirmed they would look through the window to observe or go into the room if the person was not in the bed. Showers were free of ligature points.

In the corridors there were breakout rooms, so staff would have to move around the ward to ensure patients were within their line of sight. Staff confirmed and we observed they did move around and checked on patients, those being at most risk were on frequent observations.

Seclusion rooms were on main corridors and had observation panels in the doors which were not covered, so limiting privacy. There were en suite facilities and appropriate mattresses provided. We observed a blind spot in the seclusion rooms which would necessitate the observing staff member moving from the observation room to the corridor. The intercom on Newstead ward worked for the staff side only and the patient would have to knock on the window to gain attention. Clocks were positioned for the patient to see.

There was a pictorial contraband list for the medium and low secure units. There was a system in place which identified which staff were present in the hospital areas in the event of a fire. We observed a health and safety check being undertaken on a day to night shift hand over relating to drugs, cutlery, fridge temperatures and saw daily health and safety check lists on white boards in the wards that were completed.

There was a search policy and room searches were carried out monthly and randomly.

“Our voice” patients representatives and other patients stated that personal electrical equipment was tested on the Northampton site, this resulted in long delays before they could access some of their personal electrical equipment.

Safe Staffing

We found that there were not always enough members of staff to care for people safely. Some staff and patients told us that they did not always feel safe on the wards. We saw meeting minutes which showed there had been an increase in assaults on staff and patients on the men`s reporting wards, in the last quarter, from April 2014 to August 2014. Hawkins Ward had the highest number of recorded incidents. Staff and patients told us that incidents of aggression sometimes happened because people were frustrated. We saw minutes from the men`s service patient safety meeting which acknowledged incident reports highlighting staffing as contributory factors in some incidents. We saw an action plan which showed that the senior management team were aware of this concern and there was a workforce plan in place.

Staffing levels were adapted when changes in people`s needs were identified. Where an increased staffing requirement was identified, for example if a person required 1:1 or 2:1 support, additional staff would be employed on the wards. We saw rotas which showed the wards were regularly using bank or agency staff. We observed agency and bank staff on the wards we visited. For example, Mackaness had 3 members of regular staff to 6 bank or agency staff members on the day we visited. We observed that agency staff were shown round the ward and given a brief overview of the patients by the safety nurse, but limited details about specific care needs. When we spoke with agency staff, they were not able to tell us about

specific patient care needs, stating they would ask a member of staff. Agency staff and some bank staff were not able to access the electronic notes system despite reassurance from the charity that bank staff could.

Most staff told us that there had been regular occasions when there had not been enough staff to facilitate an activity session or to escort a patient outside. We also saw this reflected in a document which showed all the ward activities which had been cancelled due to inadequate staffing levels to supervise patients. We saw notes in some patients care records; leave or activities had been cancelled due to staffing, including home visits. Patients told us that they were upset and frustrated that they could not always attend activities or leave the wards as planned. Eleven patients on Harlestone Ward gave us a letter which outlined the impact of this issue.

Staff told us that they were able to contact a manager or doctor outside of working hours. Staff explained the process for doing this and we saw on-call rotas. Medical staff confirmed that they were part of this process.

In Nottingham

Ward managers had part time administration support available and reported that there were ward manager vacancies and absences at the time of our visit.

We found that the hospital relied on agency staff to deliver a great majority of the care and this affected the continuity of care and relationships. We were told that the wards providing leaning disability and autistic services could become unsettled if the staff team changed or consisted of several new staff at one time. Patients particularly with autism find inconsistences hard to deal with and may not feel safe. Some patients told us they did not feel safe.

The provider was aware that staffing is a problem and it was on the risk register. Active recruitment was taking place to fill vacancies. There was a standard operation procedure for reporting and governance of workforce issues identifying the responsibilities of each tier of management. The hospital had a set baseline of staff numbers, and we observed rotas where these were mainly met. We saw the ward dashboard which gave summative information about staffing, sickness, turnover and vacancies. We observed a daily hospital managers meeting in which staffing was reviewed across the hospital.

We were informed by managers that the hospital always worked to a staffing level of set numbers. 90% of the agency staff were known to the hospital as regular staff. We found that on many shifts there were more non-permanent staff working. Wards generally had two qualified staff on duty. Whilst the wards appeared to have appropriate numbers of staff the skill mix and deployment of these were of concern.

All but two patients highlighted their concerns about staffing and the impact this had on their experience. Examples given were cancellation of section 17 leave, lack of activities, incidents and lack of ground leave within hospital,

We found on Rufford ward that the ward manager was covering two wards and the staff nurse in charge was on their first day on duty. We found some agency staff on this ward did not know the needs of patients. Agency staff were not able to take patients on section 17 leave. This meant that permanent staff were often escorting patients whilst agency staff covered the ward areas

We found reference to staff shortages in several of the case notes we examined. For example on one file we found a note that a trip to a future placement, (part of a planned introduction) was postponed the day before it was due to take place as no driver was available. On another we found a record that the patient was concerned that staff shortage on Rufford ward had prevented activities taking place. No observations took place in the afternoon. The person reported that he “spent almost three hours in his room and wasn’t checked at all.’ A further note on a different day in August 2014 for the same patients stated that his mood fluctuated during the day from quite settled ‘to becoming quite upset with regards to the staffing shortages throughout the day.’

Staff confirmed shortages of staff. For example we spoke to one member of the night staff. They told us that on some night shifts there was five agency staff working on the ward and this “can be scary, if no staff know the patients.” We spoke to another member of staff, They told us the night shift staffing had consisted of one permanent qualified nurse, one permanent health care assistant, and five agency staff members. We spoke with another member of staff who expressed concerns about the staffing levels on the ward. It was explained that the senior member of staff was usually in the office, which reduced the number of staff on the actual ward. Once staff breaks, escorts and 1 to 1 observations commence, the staffing levels were reduced further. This member of staff told us that they had recently

supervised all the patients alone for two and a half hours. On the day of our inspection on Rufford ward, a member of staff was asked who was in charge; the response was "I don't know." It was reported that the pressure on the staff on the ward was "unbearable" and the behaviour of patients deteriorated due to the fact that there was not enough staff and their section 17 was cancelled. On the day of our inspection, there were a number of planned patient escorts. However one escort had already been cancelled due to the staffing situation.

During our visit to Rufford ward in the afternoon we asked the staff to provide us with a breakdown of the number of patients and staff on the ward. One patient required two members of staff to be with them. We saw that the two agency health care assistants were providing this level of support. Three remaining members of staff were providing care for the remaining patients. This included the nurse in charge, and two permanent health care assistants. We observed that the ward organisational noticeboard (which provides a breakdown of tasks the staff were to complete during the shift) was not completed from 1pm onwards.

Medical staffing had undergone changes due to rapid turnover and this was a concern to patients and carers. One patient said "I don't feel comfortable with so many changes of RC (responsible clinician). My life is in their hands".

Doctors on call were able to respond within 30 minutes out of hours. The consultants on call rota was shared with consultants who worked in Northampton and lived in the area local to Nottingham.

The occupational therapy team had staff on long term leave and were recruiting to vacancies. The occupational therapy team provided a seven day service and worked three evenings a week until 8pm. However when weekend work occurred then sessions were cancelled during the week. The psychology service had 6.2 whole time equivalent (WTE) psychologists for the whole site.

The pharmacy team consisted of one part time pharmacist two days a week and a pharmacist technician once every two weeks. They were supported by a pharmacist based at the Northampton location. However, the pharmacist was isolated from the other three service locations. There were no joint meetings to discuss, share and learn good practice for consistency with each other.

Arrangements were in place to record any medicine incidents or errors. We found that although there was an open culture of reporting medicine errors nursing staff were not always informed of the overall outcomes in order to learn and change practice. The learning from these incidents would help to improve patient safety

Assessing and managing risk to patients and staff

Due to the complex needs of the people who use the service, some elements of choice and care were legally restricted, as some were detained under the Mental Health Act. Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to manage risk. The risk safety system provided an overall framework for the assessment and management of behaviour and risk across St Andrew's, Behaviours related to daily care and treatment were measured using generic levels, with little reference to individual risk assessments or care plans. Patients were allocated a level 1 – 5/6, depending on behaviour and risks. Level 1 was the most restricted; For example, all new patients admitted to the wards were placed on Level 1 or 2 (which restricted leave, visitors, and contents in bedrooms). Patients could move up or down the levels depending on their behaviour, determined by the nurse in charge or the MDT, in line with the system. For example, a minimum of 72 hours `settled behaviour` was required before moving from level 1 to 2. There did not appear to be an opportunity for patients to appeal against decisions made about levels allocated to them or clear, individual behaviour markers and goals, for change in levels. This system was not in line with Department of Health Positive and Proactive Care: Reducing the Need for Restrictive Practice guidance (April 2014) or the Mental Health Act code of practice.

The service had a number of policies in place, addressing a range of appropriate areas to manage risk. For example, policies addressing: searching, management of violence and aggression, observation, escort procedures. Most regular staff could explain how their ward used the observation policy and how observations could be increased or removed. Some staff were concerned that they were on 1:1 observations with people for prolonged periods of time, without a break or change in staff. We saw an example of how observation paperwork was completed. We noted that patients were routinely searched and checked for contraband items when returning to Bradlaugh ward, a locked rehabilitation ward, irrespective of their individual risks.

Requires improvement

Are services safe?

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

The CQC Mental Health Act reviewer looked at eleven records across the 5 wards, including seclusion records on each ward. They found that the records were kept accurately and in line with the Mental Health Act code of practice. However, we were concerned a medic did not review a patient who harmed themselves by head banging whilst in seclusion on Hawkins Ward. The progress notes indicated that following the incident, the person was observed through the door to be asleep. They were not seen by a doctor until twelve hours after the incident.

We were concerned that seclusion facilities were sometimes used for `time out`. Patients would `voluntarily` go into seclusion with a staff member for `time out`. Staff on Ferguson ward told us this was due to the low stimulus room being out of action. Staff on Hawkins told us that this was a part of some patients' care plans. We saw one example in an individual`s care plan. The plan stated that the person would use their "bedroom or a quiet room" for time out, it did not state the seclusion room. Staff we spoke with did not view this action as seclusion and it was not recorded in the seclusion records. National Institute for Health and Care Excellence (NICE) CG25 guidance and the St Andrew's service seclusion policy clearly states that seclusion facilities should not be used for the purpose of de-escalation or time out.

There was a process to report safeguarding concerns to the nurse in charge, who would inform the ward social worker. The social worker reviewed these concerns and made external referrals where they deemed it necessary. External referrals were made in line with the St Andrew's policy. A regular discussion was held with the local authority regarding all other safeguarding issues, to monitor that referrals were made appropriately. We observed that safeguarding was discussed in MDT ward rounds and that there were individual protection plans agreed from these discussions. We saw from meeting minutes that safeguarding reporting was monitored and discussed in patient safety meetings.

The agency staff we spoke with did not know where to find out about current safeguarding issues on the ward. We were concerned that bank and agency staff would not be aware of relevant protection plans. For example, when one patient had been bullying another patient. Some staff we spoke with could not clearly explain what a safeguarding concern was or when it would need to be escalated to external agencies. One staff member told us that they would not pass everything patients told them on to the ward social worker, or "everything would be called safeguarding". We were concerned that some staff may not listen to concerns raised by patients or be aware of the need to take action if they observed something that was contrary to their protection plan. The July 2014 training report that 31% of staff in the men`s service had completed their Safeguarding Level 3 training.

In Nottingham

We saw that each ward received a dashboard statement each month displaying the number of safeguarding alerts, incidents and complaints and staffing amongst other indicators. We were informed by staff that these are discussed in team meetings and handovers so that learning and action could take place. We observed a night staff handover and found the handover period was too short to discuss these; we looked at staff team minutes on Rufford ward and found no evidence of discussion.

We found in the majority of case records that risk assessments and plans were put in place on admission and updated. We reviewed case records and found that the HCR-20 violence risk assessment tools (this tool estimates a person's probability of violence) were being used. We found that HCR-20 assessments had been carried out soon after admission and repeated a year later. There was use of structured ratings demonstrating improvement and evidence of planning for discharge. Overall the ratings of risk via HCR-20 agreed with the data supplied and detailed enough to allow understanding of the relevant risk factors and their prevention and management.

There were exceptions. For example in one person's record we found no record of the HCR being completed soon after admission. Staff relied on earlier pre-admission information from 2011. Subsequently there was a single HCR-20 was provided however there were important aspects of details missing, capacity was not recorded even though the person had been identified as financially vulnerable. The fact that the patient preferred to speak to agency staff and ignore substantive staff was not regarded a risk trigger. Our view was there was no clear formulation of the case in risk terms and the overall risk rating did not take into account a serious violent attack that had happened in May 2014.

There were policies and procedures in place for observation, searching and seclusion on the provider's intranet. We were informed by staff that patients are

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routinely searched when coming back from leave. The hospital needs to demonstrate they are adhering to the Mental Health At code of practice in ensuring that consent, rights are explained to patients and searches are proportionate to individualised risk.

We were told about the observation levels that operated on the ward. These included five, fifteen and thirty minutes checks, hourly checks, and increased levels of observations such as one member of staff to one patient, or two members of staff to one patient, and line of sight observations.

We were told of the procedure for managing aggression. When rapid-tranquillisation (the use of medication to calm the patient) was used, a registered nurse would observe the patient for a minimum of two hours.

On Rufford ward one person was seen to be on two to one observations when out of the bedroom due to the risk posed to others. Whilst in the bedroom he was not observed. The care plan stated the risks, rationale and clearly stated what the person needs to achieve to come off these observations. The patient had seen his care plan and inputted into it. Observations were reviewed by the multi-disciplinary team. We looked at the observational charts; during the day when on two to one observations these were recorded on counter fraud forms which went to the funding commissioner. Hourly observations were completed on a general form and then transferred into the electronic system. The ward was in the process of introducing tablet computers to record these observations so that they would be inputted straight onto the electronic system.

The hospital had a seclusion, extra care and longer term segregation policy dated June 2014 on the intranet and staff were aware of the policy, this was due to be reviewed in December 2014.

We checked a number of incidents involving the use of restraint and seclusion, and found that these were clearly documented. We found for the month of July 2014 that the longest time restraint was used on Thorsby ward for example was 10 minutes in one case and the rest were of much shorter duration and were classified as low to no harm. The longest seclusion period was for 17 hours

The ward dashboard reports on the number of seclusion and restraints and this are shared with the ward team. In the past year ;-

- Newstead had 115 incidents of seclusion, 390 incidents of restraint, of which 148, had been prone restraint, 16 resulted in rapid tranquilisation
- Rufford has had 15 incidents of seclusion, 43 incidents of restraint, 12, had been prone to restraint, 2 resulted in rapid tranquilisation and one person has been in long term segregation.
- Thorsby had 86 incidents of seclusion, 217 incidents of restraint, and 75 had been prone restraint, 15 resulted in rapid tranquilisation and two patients were in. 2 long term segregation.
- Wollaton has had 35 incidents of seclusion, 36 incidents of restraint, 11, have been prone restraint, 1 resulted in rapid tranquilisation.

We saw from the ward dashboard that the numbers of restraints and seclusion were being monitored and there had been a gradual reduction occurring.

Patients who recently experienced seclusion said that they did not find staff supportive. The medical staff confirmed they undertook seclusion reviews and that seclusion was used often and some patients benefited from being able to initiate it. Rapid tranquilisation was not used often.

We looked at the prevention and management of violence and aggression (PMVA) care plan audit carried out by the hospital in June 2014. This identified that not all details of patients preferred ways to be managed had been copied into the care plans, None contained patient debriefing and only 63% commented about what patients said about their experience. All patients had a PMVA care plan, and identified risk triggers and preferred de-escalation methods and observation levels.

Staff were trained in PMVA. At the night staff handover we heard staff discuss observing particular individuals who were following patients around in order to prevent any violence or aggression. One member of staff summarised that aggression was managed well on the wards stating “there’s a good team” and “we try to actively engage the patients in therapeutic activities.”

We observed in the daily hospital managers meeting that safeguarding alerts raised were discussed. Reviews of safeguarding alerts and concerns were undertaken weekly and there was monitoring by the local patient safety group. A safeguarding alert was tracked through and was correctly recorded in the patient’s notes and incident forms. Some patients had safeguarding plans in place. Patients knew

what a safeguarding alert was and what a safeguarding plan was. The patients' representatives on "our voice" stated that they were frustrated as they had to wait too long to be notified of the outcome of the safeguarding alert from the local safeguarding team. Also they did not consider it to be fair to have to remain on the same ward when the perpetrator was another patient.

Whilst there was a richness of data about patients care and treatment available, agency nurses could not access the electronic records and relied on "grab notes" which had printed out care plans and risk plans. We found that grab notes were not up to date or did not have information in them. This posed a clinical risk because agency nurses would not be familiar with the person's full history

Staff informed us that there had been no formal discussions about the Winterbourne View lessons and recommendations. There was a short document summarising restrictive practices arising out of Winterbourne View and what should be considered, that had been distributed to staff. Restrictive practices were discussed during supervision sessions and supervision records confirmed this. There were some blanket restrictions in place. These did not necessarily address individual needs. For example bedtime was 11pm, access to making hot drinks and smoking ceased from 11pm. Staff stated they would make hot drinks on request.

Reporting incidents and learning from when things go wrong

Staff were aware of the incident reporting process. We saw that incident reports were dealt with in line with the St Andrew's policy and recorded on an electronic reporting system. The examples we saw showed that the information recorded in incident reports was clear and comprehensive. We were informed learning from incidents was published in bulletins on the intranet and we saw folders on each ward which contained these. We noted that few staff had signed to say that they had read the contents of these folders. Most staff could not give an example of an incident and shared learning from it. The ward staff meeting minutes we were given did not reflect that information about incidents was shared within this forum.

We were concerned that the CQC have not been sent notifications relating to incidents affecting the service or the people who use it, in line with requirements of regulation 18 of the Health and Social Care Act. For example, we requested data around the numbers of assaults on the wards. The number of incidents reported did not correlate with the number of notifications sent to the CQC.

In Nottingham

Incidents were reported electronically on the Datix system. The information was collated and looked at by the hospital safety group and the hospital quality and compliance group, and the information was cascaded to the provider wide governance groups. Wards received feedback on the number of incidents and trends. For example it was noted that more incidents occurred on a Sunday afternoon when there was a shift change over and on Tuesdays after the ward round, the ward responded by increasing staffing levels at these times. However we found generally staff were not able to describe recent learning from incidents across the organisation that had resulted in a change in practice.

We tracked through a number of incidents, restraint and seclusion incidents, these correlated with the case records.

The safety thermometer was carried out and results identified no issues relating to falls, urinary tract infections, venous thromboembolism, and pressure sores.

Serious untoward incidents were investigated and reported to the board, there was one serious incident on Thorsby ward for the period of May 2013 to June 2014.

We observed a meeting between the nurse coordinator, lead nurse, responsible clinician and other nurse managers that occurred daily Monday to Friday. This meeting discussed events from the previous evening and night such as incidents, seclusion, staffing, and a three day forward look at staffing. Overall this meeting profiled a swift accurate picture of relevant issues across the four wards with actions to be undertaken. However it was not immediately apparent who would have taken the relevant action.

Staff spoken with were aware of the bullying and harassment policy and whistleblowing policy. Staff confirmed they would feel at ease using these policies if required. However agency staff told us they did not feel confident to report.

There is a safeguarding policy on the hospital intranet. There were flow charts and telephone numbers visible on some of the wards. In the ward offices, the emergency

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telephone number, along with safeguarding information, was prominently displayed for staff to read. Staff spoken with were aware of the policy and was able to describe how they would recognise a safeguarding situation and what to do. Safeguarding referrals were discussed at each daily hospital managers meeting in the morning. We tracked through a safeguarding incident and found it had been appropriately managed. Safeguarding alerts were discussed at the multi-disciplinary team meetings.

51 staff members were injured between April 20015 and August 2014. Of these, four were reported under Riddor (reporting injuries, diseases a dangerous occurrence regulation 1985). Two were due to assaults by patients. We saw action plans in place to minimise staff injuries.

Understanding and management of foreseeable risks

We looked at the ward logs that showed staff had received mandatory training in fire, manual handling, hygiene, contraband, safeguarding, observation, and managing aggression.

Intermediate life support training and physical healthcare were merged into one training day; the hospital take up was above 50%.

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Summary of findings

Due to the complex needs of the people who use the service, some elements of choice and care were legally or therapeutically restricted. Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to manage care and risk.

Patients were commissioned to have a minimum of 25 hours per week of structured activity for each service user. The programme of treatment included occupational therapy and individual psychology sessions. Some staff told us that they did not agree that 25 hours was achievable for some patients.

There were multi-disciplinary teams (MDT) identified as part of the staffing establishment, with each team including psychiatrists, nurses, pharmacists, psychologists, occupational therapists, and social workers. Other allied professionals such as dieticians, teachers and speech and language therapists worked within the service and responded in good time to referrals. Most staff told us that the training offered by St Andrew's was excellent. We saw a comprehensive training schedule

Our findings

Assessment of needs and planning of care

We looked at ten electronic patient care records. We saw that these contained care plans for a range of physical, psychological and social issues and a risk assessment. Some of the care plans were generic and they were not always person centred and did not incorporate clear goals agreed with the person to work towards; particularly in relation to the risk safety system. We saw that comprehensive prevention, management of violence and aggression (PMVA) care plans were in place. However the care plans had not always been updated, or did not contain full information. For example, we noted a PMVA care plan on Hawkins ward contained a `?` as an agreed time period for an individual to "show settled behaviour" in order for seclusion to be ended. The `?` had remained in place despite the care plan having been updated.

We saw that notes indicated that a physical health check had been undertaken on admission. We saw that there were care plans in place to monitor specific physical health problems. For example, we saw a care plan outlining how to manage a person`s diabetes. Progress notes were completed each shift, although some bank and agency staff were not able to use the electronic notes system.

In Nottingham

We looked at care records and found they contained up to date personalised holistic nursing care plans that were evaluated during multi-disciplinary team meetings. We saw that speech and language passports were used to aid communication with some patients.

On Newstead Ward we reviewed a third of all patients set of clinical notes. We saw comprehensive assessments, risk assessment, care planning and involvement of the multi-disciplinary team. The information was kept up to date and reflected the patient's current needs. In parts, some care plans were written in the first person. However we also saw a few examples of care plans that did not demonstrate an individual's involvement. We also saw clear documentation where patients did not wish to be involved in their care plan review and a note made of why the patient had not signed the care plan. We also saw the care plans that had not been signed by key workers.

We looked at case notes on wards and found 72 hour care plans for patients newly admitted, to address the immediate care needs. Following which a full care plan was developed. We saw that patients care plans contained information under the headings of where am I now, where do I want to get to, how do I get there, how will I know when I'm there, the timescales, and who will support me. The care plans covered need type, goals, interventions, progress, timescales and who was the lead healthcare professional assisting the patient. The care plan contained information relating to mental health recovery, stopping problem behaviours, risks, getting insight, making feasible plans, staying healthy, life skills and relationships. We saw some patients had signed their care plans to confirm that the care plan had been developed with them. We saw evidence that the care plans were reviewed on a monthly basis.

We did observe in one set of case notes that food and fluid balance charts were not completed as part of care plans, We drew this to the attention of the ward manager, who explained the that the patient was eating and drinking

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more than what had been recorded on the food and fluid chart. The patient had recently had some blood tests, and actions following the blood tests were clearly documented within the patient's care notes

Patients had had a care programme approach meeting. This meeting had been attended by the patient, psychiatrist, occupational therapist, social worker, assistant psychologist, senior social worker, behavioural team advisor, solicitor, named nurse and clinical administrator. This showed us that the full multi-disciplinary team were involved in the persons' care.

We reviewed case records and found that patients did have annual physical health checks. We were informed that recruitment was underway for an advanced nurse practitioner in physical health for the hospital. .

We found that patients had detailed health action plans which had been informed by a number of assessments. However we found one person who had epilepsy did not have a care plan in relation to this despite having a seizure in 2014.

The provider has a physical care action plan following an investigation on Grafton ward. This showed an amber rating for the Nottingham location. It showed that vital signs training were implemented in April 2013 for clinical staff. The updated action plan indicated that a full day intermediate life support refresher and physical healthcare training would be delivered. It showed the take up of training was low in Nottingham. An amber rating was given for medication training. The plan was reviewed and updated and a decision made not to use e learning for the majority of medication training apart from some specific training e.g. Insulin. The plan was to includes a one day course, completion of workbook, monitoring of competency by trained assessors and programme of additional medication training for identified high risk areas e.g. clozapine, controlled drugs. Competency would be checked within the probationary period for all new nursing staff.

We visited the GP consulting room and found it appropriately equipped..The GP was not currently visiting as the contract was out for tender. Patients confirmed they were registered with GPs. We reviewed case notes to look at the liaison between unit staff and the local GP and general hospital. We found the St Andrew's team maintained regular and appropriate contact with the local medical team in diagnosing and managing a complicated and serious medical condition. The healthcare nurse was on long term leave, Healthcare nurse cover was centralised and there was a senior nurse over Birmingham and Nottinghamshire sites,with recruitment of an additional full time healthcare nurse.

A patient with diabetes explained his diabetic care plan and confirmed he has seen a dietician and a diabetic nurse specialist.

Best practice in treatment and care

The risk safety system applied to most people on the wards, although we were told of a few individuals for whom this had not been put in place. We concluded that it was a restrictive, blanket approach, not individualised to take into account understanding the individual or function of a person`s behaviour. Staff from all disciplines told us that they were concerned that the patients did not always understand the levels in the risk safety system. Some staff told us that they felt it was restrictive and did not motivate or support patients to understand their behaviour or make changes. Staff told us that the risk safety system was sometimes used inconsistently, particularly between shifts. This caused problems if patients felt staff treated people differently. Some patients told us that they had experienced this. We saw meeting minutes which showed that this issue had been raised.

Most patients we asked could not clearly explain to us what the risk safety system was, although most knew which level they were on. Patients told us that the restrictions from the levels made them angry. We saw three recorded complaints made by patients about the system. We saw that Section 17 leave and visits from family could be affected by what level people were on. Relatives told us that they felt that the system was restrictive. One carer told us that they had been told not to visit due to a change in levels. We saw an Improving Lives document which reflected that the Improving Lives team, commissioners and family members felt this system was punitive. The current implementation of this system was not in line with Department of Health Positive and Proactive Care: Reducing the Need for Restrictive Practice guidance (April 2014) or the Mental Health Act code of practice.

A behaviour management system reinforce appropriate implode disruptive (RAID) was also used for some patients on Hawkins and Mackaness wards.

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The Commissioners of the service specified that patients should have a minimum of 25 hours per week of structured activity. The programme of treatment included occupational therapy and individual psychology sessions. We saw copies of ward and individual activity plans. There was a monitoring system in place to check if people are getting activities as planned. We saw that when activities were cancelled or people were unable to attend, this was recorded. We saw a provider paper from 2013, which stated that the risk safety system should not be used to manage non-risk behaviours, such as non-engagement. However, we saw that the system was being used in this way. Patient access to occupational work pathways were also restricted depending on which level people were on. Some patients told us they felt angry that the levels and activities were linked. For example, one individual told us that if they did not attend, their level changes and they cannot go out. We also saw community meeting minutes from June 2014, which reflected that this was the blanket agreement for all the patients; that their levels would be `frozen` "unless they got up at appropriate times".

There were some activities available on the wards; for example, board games and pool. However, with the exception of Harlestone Ward, where we observed patients engaged with occupational therapy (OT) activities, we observed little ward activity or interaction between staff and patients. We were told that patients could only access the sensory room and ward kitchen with an occupational therapist, dependent on their risk safety system level. We observed patients were sat around or walking about the communal areas, throughout the inspection visits. Some patients told us that they were bored. Some patients told us that they felt angry and frustrated by this.

All patients had access to a primary healthcare service. There was a GP service and dentist on site, which was available to all patients if required. A physical healthcare nursing team also visited wards when required. We observed a physical healthcare nurse on Ferguson ward with a patient. Patients who required the services of a G.P, podiatrist, optician, dentist or physiotherapist were referred on a needs basis in order to access these services. Staff confirmed there was generally a timely response to referral

Most staff were not engaged with clinical audit of their wards. Most of the audits were undertaken by a central audit team. We saw some examples of these audits, such as health records review and an audit of the, prescribing of high doses of anti-psychotic medication. Staff we spoke with were not aware of which audits were undertaken or able to give an example of outcomes which affected their ward areas. The ward managers we spoke with were aware of action plans which were generated for their specific ward areas. We saw an example of an action plan for Bradlaugh ward and how this was discussed in their ward meetings. Some medical staff could not identify how actions from pharmacy audits, related to prescribing, were communicated to them.

In Nottingham

Staff confirmed and we saw that clinical policies were based on best guidance and practice.

There was a medicines management group that met monthly to discuss NICE related guidance and issues. One consultant acted as a second opinion appointed doctor for the CQC. We were informed that a consultant had an interest in not medicating with anti-psychotic drugs for symptoms of autism and was monitoring this.

Appropriate arrangements were in place for recording the administration of medicines. Any concerns or advice about medicines were highlighted to the person's doctor by the pharmacist. The availability of a pharmacist on site helped to improve medicine safety.

Patients did not always receive their medicines promptly. Although a pharmacist was available part time there were no facilities to provide on-site dispensing of medicines. There was an emergency drug cupboard available which senior staff on site had access to. However, when medicines were not available on site then a courier system operated to collect medicines from the Northampton location which increased the time to obtain medicines.

An initiative called having "meaningful conversations" has been introduced by the provider for nurses to do daily with each patient, which patients told us was good.

Patients have some access to psychotherapy and Thorsby ward was run as a therapeutic community which meant that psychological therapy was the main approach to treatment.

The psychology services had carried out a psychological needs analysis for the four wards in relation to anti-social and offending behaviour, mental health and wellbeing, self-management and interpersonal skills, activities of daily

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living and noncompliance. The survey identified 75% of the hospital population required anger and anxiety management, motivation to engage, social relationships and skills, violence related intervention, planning skills, communication. We were provided with the programme of intervention summary for psychology and OT outlining the group aims and focus for each group. We observed a "keeping on topic in conversation" session led by a psychologist.

The psychology department said the Autistic Spectrum Disorder group was a useful adjunct to the organisation recognising the needs of autistic patient and organising training and therapy programmes for this group of patients. We observed an "autism group" session led by psychologists which was delivered with respect and the facilitator had a good rapport with the five patients in the group who participated throughout the session. The psychologist confirmed that NICE guidance was followed on the wards.

The wards had occupational and therapeutic activity programmes. Individuals also had their own activity programme for the week. There were mechanisms to capture the uptake of activities. The wards received a daily breakdown of the take up of activities. Staff confirmed that patients did not always take up what was offered. . Activities were discussed in community meetings

There was a social group based upon the model of creative ability assessment offered. However there was only one completed plan for sessions that the occupational therapist could show us. The therapists attended forums for national groups with the patients. Patients presented at these. Care plans with occupational therapist entries were missing. We were informed care plans were reviewed and updated accordingly with all member of MDT present during the clinical reviews. There was confusion over who is responsible for the care plan when the name nurse and care co coordinator differed. The discussion regarding the care plan and content was not agreed in the MDT and left for the primary nurse to decide.

For evening activities a range of board games were purchased. The ward time table was limited to pool, cards and colouring. There is a reliance on the OT to lead and resistance from nursing staff to take over some of the activities that could be nurse led. The hospital reported nurse led activities did take place with individual patients which was recorded in the electronic patient records .

Patients were supposed to receive individual timetables; however no patients on Newstead had received one in the week visited. Speech and language therapists (SALT) held a one hour group session weekly.

On the day of our inspection on Newstead ward we saw patients participating in activities, which included a session about "positive communication".

The majority of patients raised boredom and lack of activities as an issue. The hospital provided data that stated out of 36,634 hours of activity offered 10,413 hours had been taken up in one quarter. The spread sheet we saw gave reasons such as patients not attending, without specification of the reason for non attendance. There did not appear to be an understanding that if patients were opting out of sessions that there may be underlying reasons for that.

We did not find that staff participated actively in clinical audit or could name audits that had been undertaken and discussed. Staff were not aware of the research initiatives carried out by the provider.

Wards carried out the essen climate evaluation schema questionnaire to measure the therapeutic climate of the ward. Wards generally had good scores and used the information to make improvements.

We reviewed case notes for outcome measures and found HoNOS (Health of the Nation Outcome Scales) was being used on a regular basis and provided detailed information about changes in a person's mental health status.

Skilled staff to deliver care

There were multi-disciplinary teams (MDT) identified as part of the staffing establishment. Each team included psychiatrists, nurses, pharmacists, psychologists, occupational therapists, and social workers. Other allied professionals such as dieticians, teachers and speech and language therapists worked within the service and responded in good time to referrals. There had been a number of locum doctors in post.

Most staff told us that the training offered by St Andrew's was excellent. We saw a comprehensive training schedule. There were monitoring systems in place to record when staff attended required training. The July 2014 training report that 31% of staff in the men`s service had completed their Safeguarding Level 3 training. Staff told us that they were not always able to be released from their

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wards to attend, due to staffing levels. The training report published in July 2014 reflected that there had been 29 non-attendances recorded due to staff not being released from the wards.

Staff we spoke with confirmed that they had regular supervision. We saw forms which had been signed to indicate supervision had taken place. Reflective practice and ward meetings were not always held. This depended on other members of the MDT providing support on the ward to release the staff.

In Nottingham

We saw records confirming agency staff received an induction to the hospital and to the ward. They were provided with mandatory training by their agency. Records and staff confirmed they had received a week long induction programme.

Staff confirmed that training was given to them in relation to autistic spectrum disorder, and more formalised sessions. There was also an autistic spectrum disorder specialist practitioner. There are no nurse prescribers at the hospital.

Mental Health Act, Mental Capacity Act and DoLS training was provided during induction training.

Staff and records confirmed annual appraisals were carried out. Clinical and managerial supervision was available however records identified this did not happen regularly.

The occupational therapy team provided a seven day service and worked three evenings a week until 8pm. Staff reported that when weekend work occurred then sessions were sometimes cancelled during the week. The timetables were updated weekly. The occupational therapist team decided what went on the activity programme; they decided which activities were most popular. Many patients preferred 1; 1 sessions which limit group activities. Educational courses were offered to patients. A healthy living group undertook activities of daily living, as well as 1:1 sessions.

Multi-disciplinary and inter-agency team work

There was not a clear and effective system for a comprehensive handover between nursing teams. There were set nursing teams, `A` and `B`, who worked twelve hour shifts. There was a fifteen minute handover period at the beginning and end of each shift. The nurse in charge would give a handover to the on-coming shift. There was a potential that staff only ever got a handover from the night staff. There was no opportunity for a comprehensive nursing handover and discussion about care and treatment during the day. Some staff told us that there was inconsistency between the set teams. Some patients told us that they had experienced inconsistent treatment and observed conflict between staff teams. We saw meeting minutes which also highlighted this concern.

There was a multi-disciplinary team (MDT) handover Monday – Friday 9 – 9.15am, for all MDT staff to attend. Staff also communicated by e-mail and a ward communication book. We saw daily handover documents used on Ferguson and Bradlaugh wards, although these were not consistently completed for each day and varied in quality of information. For example, some entries stated `been settled`. Hawkins ward had a weekend handover sheet to update staff coming on duty on a Monday. Other communication forums such as Care Plan Update and ward round meetings took place on all the wards. We observed two MDT meetings and a Care Programme Approach (CPA) meeting. Staff listened to each other respectfully and discussed care needs appropriately.

We saw minutes from some of the clinical team meetings and saw that care needs, safeguarding and medication issues were discussed. Due to the complex needs of some of the patients, there were external agencies, such as NHS England and the Ministry of Justice involved in treatment and discharge plans. The staff told us that there was sometimes difficulty ensuring actions were taken in a timely manner, for example, transferring a patient who was not appropriately admitted onto a ward.

In Nottingham

We observed a multidisciplinary ward round on Newstead ward. It was attended by an acting consultant who had started work that week, a psychology assistant, occupational therapist, social worker, nurse and secretary. There was a large wall mounted screen displaying the electronic record and we observed there was good participation by all disciplines. We observed a good rapport with the patients and despite the formal layout of the room the patients appeared to be relaxed. Medication was discussed without it dominating over other approaches and therapies. There were innovative suggestions made. For example diary keeping to compare the patients' personal views with staff. There were individual considerations made such as pets visiting with family

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members. Racist and homophobic issues were discussed appropriately. Contact with families and section 17 leave were discussed. However many of the leave destinations appeared to be discussed near to the unit, so not permitting full use of escorted and unescorted leave. Because of shortages of nurses few front line staff could attend the ward rounds and therefore missed out on the rich discussion relating to the treatment, care and management of individuals using the services.

We observed a night to day staff handover in which minimal handover of patient information was given relating to the patients, and highlighted behaviours that should be observed. The bulk of the information was provided by the health support worker who knew the patients. The handover did not provide time for discussion about care and risk plans. Agency nurses were expected to read notes during the night to catch up on the detail, however do not have access to the electronic notes.

We observed a multidisciplinary team ward meeting reviewing patients care and spoke to psychologists, and observed a group session led by psychologists and found that there was evidence of psychological therapies being used and an emphasis on relapse prevention.

Adherence to the MHA and the MHA Code of Practice

There were systems to scrutinise detention papers to make sure they followed the MHA and we found the detention papers appeared to be in order.

Patients were given their rights in relation to their detention every six months; However we found no evidence of repeated attempts when patients refused or were unable to understand their rights. Patients were knowledgeable about their right to an independent mental health advocate (IMHA).

Case notes demonstrated and patients confirmed that hospital managers hearings and mental health review tribunals occurred when they should.

We found some good documentation confirming capacity assessments in relation to medication and consent. However some of the records did not adhere to the MHA code of practice because they had not been completed by the current responsible clinician (RC).

Contrary to the MHA code of practice, not all case notes confirmed that patients had been informed by the responsible clinician of the outcome of a second opinion appointed doctors visit nor had the statutory consultees recorded their discussion with the SOAD. this meant that patients were not aware of the outcome of the independent review of their treatment plan.

Patients were granted Section 17 leave. Patients, staff and records confirmed that this was not always facilitated. Internal leave in the hospital was recorded alongside external leave which is not in accordance with the MHA code of practice. Some staff appeared confused about who could authorise leave. There was no record of patients being given copies of Section 17 leave forms and patients confirmed that they had not received copies. The outcome of leave was not always recorded and, when it was the patient views these were not always included.

We were informed by staff that patients are routinely searched when coming back from leave. The hospital needs to demonstrate they are adhering to the Mental Health Act code of practice in ensuring that consent and rights are explained to patients and searches are related to individual risk.

Staff had access to the Mental Health Act and code of practice. Legal advice was available when requested.

Good practice in applying the MCA

We found records of multi-disciplinary discussions about mental capacity in relation to holistic patient care. However we did not find evidence that these are recorded as best interest decisions. The advocate and social work team confirmed these discussions did take place. We did not find evidence of patients being supported by an independent mental capacity advocate but were assured that when patients do not have others to support them referrals are made.

Training in relation to MCA and Dols was provided upon induction, an example was given of a best interest's assessment meeting that was planned to take place.

Requires Improvement

Are services caring?

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

Summary of findings

We observed little activity or interaction between staff and patients on the wards we visited. Some patients told us that they were well cared for and they had no concerns about the staff. Some patients felt angry and frustrated by how they are treated, stating that staff did not listen to them and they did not like how staff spoke to them.

There was little evidence that patients or their carers were actively involved in writing or reviewing their care plans. Most patients we spoke with did not have a copy of their care plan and could not identify goals. Some patients were aware that they could request a copy.

There was some support and engagement projects with the patients on the wards from the Patient Experience team. There were patient representatives on the wards who told us they felt listened to in the meetings they attended.

Our findings

Kindness, dignity, respect and support

We observed little activity or interaction between staff and patients on the wards we visited. The exceptions where with the exception of Bradlaugh ward, where a healthy living fayre was taking place, and Harlestone, where patients were involved in OT activities.

Patients gave a varied view of how they were treated. Some patients told us that they were well cared for and they had no concerns about the staff. Some patients felt angry and frustrated by how they were treated, stating that staff did not listen to them and that they did not like how staff spoke to them. Some staff told us that they were concerned that the restrictive routines in place affected how they were able to care for people individually. For example, the emphasis to meet the 25 hour activity target took priority over what the individual might want to do.

In Nottingham

On Thorsby ward the model of a therapeutic community had been introduced. Staff were passionate about using this model to develop a culture in which there was open discussion and challenge and promotion of responsibility between staff and patients using the services.

We spent some time observing the general interactions on Newstead ward. We saw that there was a good rapport between the patients and the staff. We heard respectful interactions from staff towards patients, and a relaxed atmosphere prevailed, with healthy banter.

On Rufford ward staff and patients told us, and we observed, some staff treat patients with respect. We also observed that a person who had touched a female member of staff in a jovial way was reprimanded in front of other staff and us. This could have been managed privately. However we heard from both staff and patients that some staff do not work well in the service. When we were on the ward we heard one staff member swearing in the office. We discussed this with the nurse in charge who agreed this was unacceptable and would be dealt with.

In relation to Rufford Ward we learned that patients had raised serious concerns about staff attitudes at community meetings. This prompted an investigation, which uncovered some unacceptable behaviour by staff in front of patients. We were told it has been referred to senior management. Patients gave us examples which included staff swearing at patients. Some staff told us they have raised concerns about the behaviour of other staff, and had been disappointed by the response of management. One said 'there are a lot of good staff who are not appreciated, but there are a lot of bad staff who are never criticised. We report and nothing happens.' One staff member told us they had witnessed a senior member of ward staff on Newstead, swear at a patient.

One patient told us he that had complained when a female staff member ignored him when he refused to 'hi 5' her, as he said it was contrary to his culture. This one patient said on another occasion he complained when a female member of staff refused him access to his toilet, when he badly needed to use it, as there were too few staff around and the dining hatch was open. He subsequently soiled himself and was embarrassed. He has complained to the hospital. We noted his PMVA care plan clearly records his wish not to be touched by female staff. He told us some staff makes fun of his religion. He said there is no Imam but

Are services caring?

Requires Improvement

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this is not a problem for him as he is happy to talk to the Chaplin. Another patient told us that during Ramadan staff were dismissive of his fasting. He said halal food was provided, but was not always adequate and he had to microwave and provide it himself. He said he was unable to celebrate Eid as no Imam was available.

Not all patients we spoke to knew who their named nurse was. However records indicated that 1:1's did occur on a weekly basis for most patients.

The involvement of people in the care they receive

Patients were encouraged to attend their care management meetings. We saw that some patients were supported to complete a form to take in with them, or give to the MDT if they did not wish to attend. In the CPA meeting we observed, it did not appear that people were listening to the patient. We observed that sometimes clinicians used language that the person could not understand.

There was little evidence that patients or their carers were actively involved in writing or reviewing their care plans. Most patients we spoke with did not have a copy of their care plan and could not identify goals. Some patients were aware that they could request a copy. On Bradlaugh Ward the patients had copies of their care plans in their rooms but not in a format that they could understand. For example, one person had a written care plan but they were not literate. Hawkins ward staff advised us that people didn`t have copies in order to protect their personal information. None of the patients we spoke with had drawn up, or had a copy of, a health action plan.

Independent advocacy service (Voiceability) was available to all patients. Each ward had an advocate who visited regularly. Advocacy could also be contacted by telephone. Patients told us that they knew how to contact an advocate. We saw a report from Voiceability for July 2014, which showed that patients were contacting them regularly.

Each ward had weekly community meetings, with patients and staff. We saw meeting minutes from these. There were some support and engagement projects with the patients on the wards, from the patient experience team. We spoke with patient representatives, they told us that they felt listened to in meetings they attended.

In Nottingham

We observed a coffee morning in the café for charity manned by patients. We also saw a newsletter called "news of the wards" produced by patients for other patients.

A representative from "our voice" service user representative group had participated in developing a training video and had presented it at the providers training conference for nurses. Some patients had been involved in interviewing of staff for jobs. The provider prospectus for its recovery college offered work placements in Nottinghamshire; there were limited opportunities and take up for this.

The "our voice "service representative group have produced an action plan relating to the five CQC domains, and also participated in discussions about provider wide initiatives and policy.

There was information provided about advocacy on the wards including independent mental advocates. Advocacy visit the wards three days a week. Patients we spoke with knew who the advocate was and confirmed that they had used the advocacy services. Advocacy services reported that patients who had been subject to a safeguarding investigation often did not appear to know what the outcome was and what safety plans were in place. Advocacy were not made aware of any safeguarding meetings and patients were not always asked if advocacy support was required when safeguarding alerts were made.

We were informed by staff that patients were being encouraged to chair their own care programme approach (CPA) meetings. Patients reported this rarely happened and appeared to be dependent on the relevant RC.

We observed that c community meetings were held on wards and notes kept of the meetings.

"Our voice" patient representatives and patients we spoke with were concerned about being placed far away from their homes. Some had elderly parents who could not travel long distances. Where families could visit they were able to go the family room or café. Some patients had visits arranged to see their family. Staff told us that if relatives struggle with travel costs, the hospital would contribute up to £50 towards the cost.

Are services caring?

Requires Improvement

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

We found staff responding positively to patients who experienced bereavement. During our visit a patient was being taken to another part of the country to attend a funeral, the person told us that this was the second time that he had been allowed to attend a funeral.

We saw that bedrooms were open and patients could choose to go to their rooms. There were also two or three lounges on each ward so that patients could have quiet time. There were de-escalation rooms that had been decorated by patients which were used only for de-escalation.

Patients had access to a phone box, located in a quiet position on each ward. They used call cards which they paid for. We were told that If they do not wish to use their call card credit to call the CQC, they have to ask staff to connect them. Some patients said this compromised their freedom to talk openly to the CQC. Patients could contact their advocate, without paying for the call, or involving staff, who could then contact the CQC on their behalf. We observed that both the advocacy phone number and the CQC phone numbers were visible in the phone booths.

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

Referrals and admissions to all the wards were accepted from other St Andrew's services, and NHS or independent healthcare providers nationally. Pathway bed management meetings took place on a weekly basis. There were some patients who were not on appropriate wards for their needs.

We were told by staff and patients that staffing arrangements sometimes affected patient access to activities, outside space and leave arrangements. We saw that there were blanket restrictions in place as part of the overall ward routines.

There was a complaints procedure, although we did not observe easy read information about this clearly displayed on the wards. Patients told us that they did not feel that their complaints were always listened to or acted on

Our findings

Access, discharge and bed management

Referrals and admissions were accepted from other St Andrew's services and NHS or independent healthcare providers nationally. We were advised there was a pre-admission assessment form which was completed for all patients. The patients were assessed by a consultant psychiatrist or senior nurse from the specific ward that they had been referred to.

Pathway bed management meetings took place on a weekly basis. We saw minutes for these meetings. There were some patients who were not on appropriate wards for their needs, and they had been there for over a year. For example, two patients on Bradlaugh, a rehabilitation ward, needed constant staff supervision and high levels of care. Staff told us that this had an impact on the ability of staff to promote the rehabilitative aspects of the ward for other patients.

In Nottingham

Patients receiving care at Nottingham are placed from anywhere in the country. Beds are always available on return from section 17 leave and patients are not moved from wards during an admission episode. The site did not have a psychiatric intensive care unit.

The length of stay from patients being admitted in 2008 to present ranged from 55 days to 2132 days. The mean bed occupancy was 89 – 100% across the wards. We looked at the data for referral to assessment and found these to be within the targets set which on average took five days. The data however showed there was variation in waits from assessment to treatment.

We looked at data for July 2014 which showed there had been two delayed discharges and no readmissions. Patients were involved in planning their discharge from the point of admission. The effectiveness of treatment was reviewed regularly so that discharge plans could be implemented. Delayed discharge was seen as a service failure and investigated. Patients were discharged with a plan and patients were supported during transition.

We reviewed case notes and found that discharge planning was included in care plans. Overall we found good evidence of discharge planning between St Andrew's and other agencies. We saw evidence of involvement of the person and their family in the process. We met with the social work team and found they were proactive in keeping commissioners and community teams involved in order to minimise the risk of discharge and transfers being delayed. We spoke to patients who were being prepared for transfer along their clinical pathway, they had been involved in visiting their next placement and spoke positively about their move.

However we spoke to some patients who were not clear about what had to be achieved before discharge. One person who had a my shared pathway plan stated he did not know what was meant by the general term he would be discharged if showed "good behaviour".

Patients were supported to access health and social care services from other providers. There were agreed protocols and care pathways with acute services.

The ward environment optimises recovery, comfort and dignity

Requires Improvement

Are services responsive to people's needs?

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

Hawkins, Harlestone and Mackaness, were in newer facilities, which met low and medium secure standards. The facilities were single sex and adhered to safety, dignity and single sex guidance. The ward environment was adapted to meet the needs of people with a physical disability. For example, corridors were wide, there was lift access and disabled bathroom facilities. These wards had access to a designated space within the building for visitors who had children with them and rooms available for private meetings.

The other wards we visited were in an older part of the hospital. It had been acknowledged by St Andrew's and recorded in previous CQC inspections, that these wards were not suitable to meet patient needs. Several of the wards we visited across the service did not meet NHS England environment standards so were part of the organisation's project to upgrade wards to meet the standards required. Bradlaugh and Ferguson wards were due to be moved by January 2015 as part of this overall project. These wards were not accessible for people with significant physical disability, requiring wheelchair access. We saw there was visitor space and private rooms available away from communal areas.

Hawkins, Mackaness and Harlestone Wards had direct access to outside courtyard spaces. Bradlaugh and Ferguson Wards were on the upper floors, but had access to garden space in the grounds and a roof terrace smoking area. Patients could access outside space but this was dependant on their leave status, risk safety system level and the ward staffing numbers ability to facilitate their leave safely. We were told by staff and patients that staffing arrangements sometimes affected patient access to outside space.

Each ward had kitchen facilities that could be accessed by patients. All access was escorted and patients were able to prepare hot and cold food and drinks, only if it was part of their occupational therapy plan. We did not observe any patients doing so during our inspection. The wards had set times when drinks were provided, although patients could ask for drinks outside of these times. There were ward restrictions which limited patient access to hot drinks.

There were weekly meetings on each ward which the chefs attended to obtain feedback and comments from patients. We observed a meeting that took place on Mackaness ward. Patients told us that the food was generally quite good although there was a limited choice. The menu we saw had one hot meal option or sandwiches.

In Nottingham

The hospital had a full range of rooms and equipment to support treatment and care. There were quiet areas on the ward and a room where patients can meet visitors. Patients were able to make phone calls in private. Patients had access to fresh air in outside spaces.

We saw the courtyard within the centre of the hospital was pleasant and well-maintained. Leading from the courtyard were the wards, the sports hall, music room, IT room with skype, video conferencing , a multi-faith room, activities of daily living kitchen, library, art and crafts room, café and GP surgery. Animals were brought in for patients to care for. We observed a dog and tortoise in the court yard being attended to by a patient.

On each of the wards we saw photographs of the staff team displayed. There was provision of accessible information on treatments, local services, patients' rights, how to complain in easy read format although it was not extensive.

Ward policies and procedures minimise restrictions

Due to the complex needs of the people who use the service, some elements of choice and care were legally or therapeutically restricted. However, we saw that there were blanket restrictions in place as part of the overall ward routines. For example, cigarette breaks were to be taken hourly when staffing allowed, drinks were at set times, access to bedrooms was restricted to allocated times of the day, and there was no access to the kitchen or sensory rooms unless with an occupational therapist. The risk safety system levels also determined whether a person had a bedroom key or what a person could keep in their room. For example, level one meant that patients could only keep a few personal belongings. Some of these ward procedures were outlined in the ward operational policies.

There was a St Andrew`s service wide visitor's policy. This stated that visitors could only attend the wards after giving notice and with prior agreement from St Andrew's. This also applied to legal representatives and was irrespective of individual circumstances or risks. It was also in place on the

Requires Improvement

Are services responsive to people's needs?

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

wards which were not considered to be medium secure. In addition to the service wide visitor`s policy, visitors could also be restricted dependent on the risk safety system level the person was on.

Most of the patients on the wards we visited were detained under the Mental Health Act. We noted that Section 17 leave arrangements we looked at were linked to the generic risk safety system. For example, if someone changed risk safety system level, their right to access their Section 17 leave could be affected.

In Nottingham

We observed that patients were able to personalise their bedrooms, on Thorsby ward they had also decorated the de-escalation room.

Patients on the wards could make hot drinks between 8am and 11pm after which staff would make drinks on request.

Meeting the needs of all people who use the service

The patients on the wards had varying levels of cognition and literacy. For many this meant that terminology needed to be simplified and presented in more basic and pictorial forms. We observed limited easy read signage or information displayed on the wards. All wards had Speech and Language Therapy input, educational support, advocacy and occupational therapy staff to support staff and patients in communication. However, we saw limited examples of patient forms and information that were clear and in easy to read format. For example, most patients were given copies of activity schedules which were complicated and difficult to understand.

The men`s service had a full time dietician who worked across all of the men's wards. There was a nutritional screening tool to generate referrals through to the dietician as required. The dietician held both individual and group sessions. We were advised that there was capacity to meet dietary requirements of religious and ethnic groups.

In Nottingham

Information leaflets were available on request in languages spoken by patients who use the service. There was also access to language line for interpreting services.

There was choice of food to meet dietary requirements of religious and ethnic groups, for example halal meals. Snacks were accessible during the day. Not all patients we spoke with were happy about the standard of food or the portion sizes.

Listening to and learning from concerns and complaints

There was a complaints procedure, although we did not observe easy read information about this clearly displayed on the wards. Patients told us that they knew how to make a complaint on the wards. We saw the complaints records which showed that there had been nineteen complaints across the mens' learning disability wards since January 2014. However, we saw examples of complaints which were not on this document. The Hawkins community meeting minutes showed that patients had requested that senior management attended to hear their concerns. It was not clear how this had been acted on, nothing was recorded and staff members we asked did not know.

Patients told us that they did not feel that their complaints were always listened to or acted on. Patients told us that they did not get always feedback from their complaints. For example, one person told us that they had complained about a bank staff member, they did not know what happened following this. Although, one patient also gave us an example of how their complaint had been resolved to their satisfaction.

Some staff members told us that the patients complained frequently. We saw there was a policy in place to manage `frequent complainers`. However, it was not clear how this was used at ward level to learn from people who made frequent complaints and manage individual issues appropriately. We were advised that complaints received on the wards were discussed in ward manager and patient safety meetings; where they would be reviewed to identify themes and share learning points across all services. Independent investigations were undertaken if complaints were `upheld`. However, most complaints were recorded as `not upheld`, if they had been resolved at a local level. All complaints are reviewed for learning these are discussed at the community, ward, service meetings, are included in the Quality Dashboard and form part of the reporting directly into the executive team on a weekly basis.

In Nottingham

We found that patients knew how to complain and saw complaints leaflets on the wards. Staff knew the complaints process and resolved many complaints on the ward. We saw data that showed in the last twelve months there had been 25 formal complaints of which one was upheld and one partially upheld.

Requires Improvement

Are services responsive to people's needs?

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

Patients told us they were not satisfied with the complaints process. They felt that their complaints were rarely fully addressed and often did not receive a clear response. They reported that they chose to ask the advocate to raise their concerns directly with the hospital director, who did respond. Advocacy confirmed this and gave an example of a complaint raised in February on behalf of a number of patients across the hospital, When the complaint was followed up, the response was that the issue which related to food, had been resolved as the hospital has set up a food group. Patents had not been told this was in response to the complaint. Advocacy were concerned that when a complaint on behalf of a patient is raised, the hospital does not treat it as a formal complaint. Advocacy were in discussion with the hospital about this.

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

Some staff told us that there was little engagement with senior managers or the organisation`s values. We were told that many of the governance, care and treatment processes were centrally administrated.

Most staff working directly on the wards told us that they felt stressed and did not feel valued or supported by the organisation. Staff told us that it was difficult working with high numbers of bank and agency staff in very challenging environments.

Staff generally felt able to raise concerns with their immediate line manager or senior nurses. The managers we spoke with, told us that they felt that their immediate service manager was supportive and listened to concerns that they raised.

Our findings

Vision and Values

We were told that many of the governance processes were centrally administrated. For example, monitoring of staff training requirements, supervision and audits. The ward managers then followed up on ward level, as indicated in a centrally administered ward action plan. Some care and treatment processes were also centrally managed, for example arranging care programme approach (CPA) meetings, which meant that CPA reports could be written several weeks prior to the meeting taking place which might not include up to date information and there was little flexibility to change dates if required. We were told that many of these processes were administratively time consuming. Shift time direct care and governance activities were also largely centred on the minimum 25 hours a week ward activity schedule, rather than individual ward requirements.

There were recognised difficulties in ensuring that the wards had the correct staff skill mix for the patients' needs. There were regularly high numbers of bank and agency staff used across the wards. Ward managers were not able to directly book staff. Staffing requirements were centrally managed through the site nursing bureau. Sometimes staff were moved between wards to help with their staffing arrangements.

Incident reporting and safeguarding processes were consistent across the wards. All serious untoward incidents (SUI`s) were reportedly discussed within the patient safety group and ward manager meetings and reviewed as required, determined on the severity of the incident. Data from incident and safeguarding reports was collated through both the local and provider wide Patient Safety Groups. We saw meeting minutes which reflected this.

In Nottingham

Staff were not entirely sure of the organisation's values and strategy. Only Thorsby ward was able to show us its team objectives and had a clear vision for developing a therapeutic community. Staff know who the most senior managers in the organisation were and reported some visits had been undertaken by senior managers. The hospital manger was visible and it was evident that patients knew the hospital manager and had a good rapport. Patients informed us that they rarely saw the ward managers. Ward managers were described as being in the back office or in meetings.

Good governance

Ward managers had part time administration support available and reported that there were ward manager vacancies and absences at the time of our visit.

There were monitoring systems in place to demonstrate staff had received mandatory training and that staff were appraised. Supervision was provided although not consistently.

Shifts had a minimum number of core staff. However a majority of the staff were agency and outnumbered the permanent staff, agency staff did not know all ways know the detail of patients care.

Leadership, morale and staff engagement

Staff from across all disciplines told us that a lot of the care and treatment processes were centrally decided. Some staff told us they did not think that there was enough flexibility to work differently with different patient groups or individuals. Some staff did not feel engaged with service developments.

Most staff working directly on the wards told us that they felt stressed and did not feel valued or supported. Staff told us that it was difficult working with high numbers of bank and agency staff in very challenging environments. Staff were leaving substantive positions to become bank staff.

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.

Some staff had raised concern about the inconsistent team working between set `A` and `B` nursing teams on some wards. Some allied health staff were concerned about increased workload and impact on care delivery, as a result of new ways of working being introduced. The staff we spoke with identified that overall morale and team performance had been negatively affected over the past year.

Staff generally felt able to raise concerns with their immediate line manager or senior nurses. The managers we spoke with, told us that they felt that their immediate service manager was supportive and listened to concerns that they raised.

In Nottingham

A staff survey had been carried out and an action plan was in place

Staff were informed of the whistleblowing, bullying and harassment and grievance policies during their induction and the policies were available on the intranet. All staff apart from agency staff stated they would use the policies if required.

Staff had access to counselling services.

The ward dashboard reported on the monthly sickness and absence rates for staff for example there were seven days average sickness rates on Newstead ward in June 2014 and 12 in July 2014.

Staff meetings were set, however managers stated that it was a struggle to get staff released from wards to attend.

Staff had access to clinical and managerial supervision and a log of this was kept on the ward. The ward log on Rufford showed that supervision did not occur on a monthly basis.

We joined a reflective practice session which was chaired by a lead psychologist. The session occurs every three weeks. We heard discussions about the use of de-escalation and distraction. Further discussions took place about how the information from this session would be shared with other staff working within the ward. We heard that there was a nurses' forum which was due to start in October 2014 and an existing health care assistant forum. It was discussed that debriefs, following serious incidents, do not always happen, and this was being addressed. It was noted that bank staff were "generally aware" of how to manage situations on the ward through learning from the permanent members of staff, however they might not had had the opportunity to read the patients' care plans. There was discussion about attitudes and values, followed by the planning of the induction of a new responsible clinician to the ward

The pharmacy team were supported by a pharmacist based at the Northampton location. However, the pharmacist was isolated from the other three service locations. There were no joint meetings to discuss, share and learn good practice for consistency with each other. Promotional opportunities were reportedly good. However additional training to assist with promotional opportunities was limited. The member of staff would recommend the provider as a place to receive care or to be employed.

Commitment to quality improvement and innovation

St Andrew's had recently introduced a dashboard system which enabled them to monitor quality and performance at ward level. Senior managers reported that there were a number of forums, such as the patient safety group, clinical governance group, and a quality and compliance group which all regularly met to monitor quality and performance, as well as identifying trends from incident reporting. We saw meeting minutes from some of the groups, which showed information was shared and actions agreed.

We were advised that HONOS was used as an outcome measurement, and Makeness Wards had recently participated in the overall William Wake House `self` and `peer-review` parts of the assessment organised by Quality Network assessment for Forensic Mental Health Services.

In Nottingham

Each ward had a monthly ward dashboard which provided key performance indicators to gauge performance in the areas of safety, effectiveness, care, responsiveness and leadership. Some wards were able to clearly identify improvements being made in seclusion and incidents.

The quality network for mental health services undertook a peer review audit in February 2014. St. Andrew's Nottingham met 92% of medium secure standards. The unit met 100% of the criteria in areas of, physical security, safeguarding children and visiting policy, clinical and cost effectiveness, accessible and responsive care, environment and amenities and public health. Areas such as serious and untoward incidents, handover process and support for carers were identified as areas in need of improvement.

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.

Documentation audits were being carried out to ensure improvements in recording.

Staff were not able to say what research was happening in the provider and their involvement it.

There was a "principle of nursing practice group" which they were implementing and monitoring the principles of dignity, care, risk and communication, team work. This had not yet been evaluated.

Staff had appraisals in place and had interim appraisals meetings; we saw well completed forms, and found that staff was supported in their development. Staff stated and we saw that the provider provided a comprehensive induction programme.

Key performance indicators for mandatory training were collated monthly. These showed that nursing and medical staff had 100% achievement for basic life support and immediate live support and nursing and psychology staff had 100% for annual mandatory training. The remainder of the training groups were below the 90% threshold. Rufford and Wollerton were below 100% compliance and bureau staffs' compliance was low.

Agency staff received an induction from the agency and a local induction on the ward. Agency staff did not do a security induction. Agency staff are shown where the care plans are and advised to read these and the risk assessments. They do receive PMVA training and life support. Supervision is coordinated through the Northampton site, they are not offered clinical supervision and did not have whistle blowing or bullying and harassment discussed with them. They told us they would not feel comfortable following the whistleblowing process.

Staff can access line management courses, a Mary Seacole leadership course and shadow the ward manger. Continuous professional development is also supported by the organisation.

We saw the hospital's quality improvement plan displayed in the foyer. This provided information about patient safety, patient experience and clinical effectiveness. We also saw information displayed about the 6 Cs, courage, care, communication, compassion, competence and commitment.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **How the regulation was not being met:** Risks, benefits and alternative options of care and treatment were not discussed and explained in a way that the person who uses the service understands. There was not always clear involvement of patients and their carers/family in agreeing care plans and risk assessments and ensuring people have copies of these Regulation 17(1)(b)(2)(b)(c)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **How the regulation was not being met:** We found that there were not always enough members of suitably skilled and experiences staff to care for people safely. There was high use of agency and bank staff who did not always have adequate information about individual patient care needs. In Nottingham • There was inadequate skill mix and deployment of staff to meet the therapeutic needs of patients. • Rufford ward had a ward manager covering two wards and the staff nurse in charge was on their first day on duty and did not know the ward very well. • There were more agency staff than permanent staff on many shifts.

Compliance actions

- Agency staff were not able to take patients on section 17 leave. This meant that permanent staff were often escorting patients whilst agency staff covered the ward areas.
- Some agency staff on Rufford did not know the needs of patients. At one point during our visit on Rufford there were not enough staff.

Regulation 22

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **How the regulation was not being met:** **Patient care and risk was not assessed, planned and managed based on individual needs. There was an emphasis on generic, restrictive risk management processes, including restricting visitors and leave, which are not in line with current Department of Health guidance, the principles of the Mental Capacity Act or the Mental Health Act code of practice.** In Nottingham • Patients using services had not been provided with a copy of their section 17 forms and leave facilitated. • Blanket searches had occurred without take into account individual risk and consent. Regulation 9 (1)(b) (i) (ii) (iii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **How the regulation was not being met:**

Compliance actions

Not all wards had resuscitation equipment. There were a number of locked doors, stairs and potentially an unpredictable patient group, which may impact how quickly the equipment arrived where it was needed

Regulation 16(2)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

How the regulation was not being met:

The shift patterns did not allow for a comprehensive handover and nursing discussion and there were concerns raised in relation to inconsistencies and conflict between the set teams.

Regulation 10 (2)(d)(I)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

How the regulation was not being met:

Some staff did not have training and understanding about safeguarding

Some staff did not demonstrate understanding about appropriate use of seclusion facilities.

Regulation 23 (1)(a)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

How the Regulation was not being met:

Compliance actions

The provider has not sent notifications relating to incidents affecting the service or the people who use it in line with requirements Care Quality Commission (Registration) Regulations 2009.

In Nottingham

- There was a lack of adherence to the Mental Health code of practice;-
- Current responsible clinicians had not documented the capacity and consent.
- Had not documented the outcome of SOAD reviews of treatment, statutory consultees had not recorded their discussion with the SOAD.

Regulation 18 (2) (a) (ii) b (ii) (e) (f) (g) (I)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **How the Regulation was not being met:** Seclusion facilities were being routinely used for de-escalation and time out and not recorded as seclusion. Regulation 11 (1) (a)