Requires Improvement

St Andrews Healthcare

Long stay/forensic/secure services

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 – Mens Service	1-121538205	Fairbairn Ward New Grafton Ward Rose Ward Robinson Ward Cranford Ward Foster Ward	NN1 5DG
St Andrew's Healthcare – Womens Service	1-121538225	Thornton Ward Sitwell Ward Seacole Ward Sunley Ward Spencer North Ward Spring Hill House Hereward Wake Ward	NN1 5DG
St Andrew's Healthcare Essex	1-121538312	Forensic and secure core services at St Andrew's Healthcare Essex	SS12 9JP

Summary of findings

St Andrew's Birmingham	1-121538294	Northfield Hawkesley Speedwell Edgbaston Hazelwell Moor Green Lifford Hurst	B30 2XR
St Andrew's - Nottingham	1-233736027	Thorsby Newstead Rufford Wollerton	NG18 4GW

This report describes our judgement of the quality of care provided within this core service by St Andrews 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.

Where applicable, we have reported on each core service provided by St Andrews 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 Long stay/forensic/ secure services	Requires Improvement 
Are Long stay/forensic/secure services safe?	**Requires Improvement** 
Are Long stay/forensic/secure services effective?	**Requires Improvement** 
Are Long stay/forensic/secure services caring?	**Good** 
Are Long stay/forensic/secure services responsive?	**Good** 
Are Long stay/forensic/secure services 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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Overall summary

We found that generally environments were clean, the design and layout of some wards made lines of sight difficult and some blind sports were found in seclusion rooms and bedrooms.

Ligature risk and environment audits were undertaken every six months. The clinic rooms were fully equipped. However we found variable practices when it came to checking and recording of resuscitation equipment. Some of the equipment was not checked with the frequency that it should be.

Staff undertook an audit of ligature points once a year these had identified some ligature risks and there were contingency plans in place to manage these.

There were concerns raised across the forensic services around staffing levels. We found that whilst there was a recognised tool used for identifying peoples' dependency needs, there were some issues around ensuring the correct numbers of staff were available. We were told by staff and patients that these reduced numbers impacted on the patient experience. We found high levels of agency and bureau staff being used. Sometimes the nursing staff did not have the relevant skills needed for the patient groups.

Staff had received safeguarding training and demonstrated that they knew how to protect people from harm.

Staff did not always follow the seclusion policy with regard to seclusion reviews with patients.

Staff managed medicines safely on most wards. However, we found that medicines on one on site pharmacy were not stored and disposed of safely. The provider's medicine management policies were not always followed by pharmacy staff.

Staff we spoke with had a good understanding of the incident reporting system. The provider used a 'Datix' system to report incidents and there were systems in place for reviewing and learning from these incidents to prevent a reoccurrence.

Patients had well written risk assessments and care plans. Health plans were in place. Care programme approach meetings took place regularly.

Staff assessed outcomes for people through use of the Health of the Nation Outcome Scales (HoNOS) secure assessment tool. We found that a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE) took place.

We found effective multi-disciplinary working (MDT) within the services to meet people's needs.

We saw clear written procedures in place regarding their use of the Mental Health Act and the Mental Health Act code of practice. We found however that these were not consistently adhered to.

Advocates were available to people throughout the hospitals and most people we spoke with told us they were aware of their rights.

We saw from patients' records that the provider used the my shared pathway (MSP) approach, which is a recovery and outcomes based approach to the planning and delivery of care.

We found blanket restrictions in place on most wards we visited such as no patient internet access and doors being locked during the day.

Most staff were aware of the senior management within the provider. However, some staff told us that they felt there was a disconnect between the executive team and the teams on the wards.

The staff were aware of the provider's board members, but were not clear about the provider's strategic direction or core values.

The ward managers had a good understanding of the risks on the wards and within the service this showed that information was shared and promoted learning.

We were told that there were insufficient occupational therapy staff which led to some staff feeling unsupported and affected the patient experience.

Most staff reported that they felt supported by their manager. They told us they had undertaken training and received supervision, had access to team meetings and had an appraisal to ensure they were competent and

Summary of findings

confident in their role. Most staff reported managers were approachable and they were effective leaders. Supervision practices were variable however across the sites.

Patients and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys.

Summary of findings

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

Are services safe?

Requires Improvement 

Safe and clean ward environment

- In Northampton, the design and layout of some wards made lines of sight difficult.
- In Northampton, we found ligature risk and environment audits were undertaken every six months. We saw that some ligature risks had been identified and there were contingency plans in place to manage these.
- The clinic rooms were fully equipped and resuscitation equipment was checked regularly and recorded.
- In Northampton, some of the wards were not clean. Wards in William Wake House showed a better state of cleanliness.
- In Essex, we found that the wards were clean and staff practised safe infection control procedures to minimise the risk of cross-infection.
- In Nottingham the environment was clean;
- We found blind spots in the seclusion rooms and bedrooms in Nottingham.
- In Birmingham, we found that systems were not in place in the kitchen used by the people in Northfield ward to ensure that food was safely stored.
- In Nottingham, we found that the resuscitation equipment was not checked on a weekly basis as required.
- In Birmingham the seclusion room in Northfield was not safe at the time of our inspection, but was made safe following this. In Edgbaston ward the seclusion room intercom was not clear so that people using this were not able to hear staff and summon assistance if needed.

Safe staffing

- The provider staff booking system allowed for special requests to be entered such as staff trained in Bristsh Sign Language. However, Fairbairn ward management in Northampton were unaware of this fact and highlighted the risk as a result that, although the ward had an interpreter available at least 10 hours every day, this still resulted in periods when patients' were not able to communicate effectively with staff who were allocated to their wards.
- In Northampton, some agency staff and some bureau staff did not have access to the electronic notes system.
- In Essex, systems were in place to ensure adequate staffing and skill mix. For example, we found that the provider used a recognised tool for identifying people's dependency needs and

the level of staffing required. Nursing staff rotas were planned four weeks ahead. However some concerns were identified across this location about the high use of bureau and agency staff on the wards.

- In Nottingham we were told by staff and patients that they were concerned about staffing. These were that the staffing skill mix and deployment had an affected on the patient experience.
- There were enough staff to provide safe care. The number of staff was increased to meet people's needs and ensure their safety. However, we found in Speedwell ward that most staff did not take their breaks which could impact on people's safety.

Assessing and managing risk to patients and staff

- In Northampton, Sitwell ward was not consistently documenting patients' review of restraint.
- In Northampton, Sitwell ward was not following St Andrew's seclusion policy with regard to seclusion reviews with patients
- On Seacole Ward, there were errors in the recording of medication administration.
- In Essex, staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort
- In Essex, staff undertook risk assessments. Management plans were available for people and the environment to keep them and others safe.
- In Essex, staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort.
- In Essex, we found that improvements were required as the services provided were not always safe. Actions from ligature audits were not followed through on one ward and care and treatment records were incomplete in respect of one person's physical healthcare needs. This meant that people may be at risk of unsafe care and treatment.
- In Nottingham, we found that the resuscitation equipment was not checked on a weekly basis as required.
- In Nottingham, we observed handover of care being given between shifts. We saw that these were too short and there was little meaningful information shared.
- Staff and patients understood the safeguarding processes. Patients were concerned that feedback on the outcome took too long.

Summary of findings

- In Birmingham, we found that medicines were managed safely on the wards. However, we found that medicines in the pharmacy were not stored and disposed of safely.
- In Birmingham, systems were not in place to ensure that staff had the information needed from people's blood test results to ensure that the correct dose of medication was prescribed.
- In Birmingham, staff had received safeguarding training and demonstrated that they knew how to protect people from harm.
- In Birmingham, staff were trained in managing violence and aggression. We found that restraint was used safely and only as a last resort.

Reporting incidents and learning from them when things go wrong

- Staff we spoke with had a good understanding of the reporting system. The provider used a 'Datix' system to report incidents which ensured that ward managers were aware of all the incidents which were reported.
- Staff told us they had access to support through debriefing after incidents but this was not always formal.
- There was an incident folder available on the wards in a staff area. Staff who were not able to attend meetings had sight of minutes and were asked to sign to ensure that they had read them.
- In Essex we found staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.
- In Nottingham we found there were systems and processes to monitor staffing, incidents and safeguarding, which were summarised in a ward dashboard.

Are services effective?

Requires Improvement

Assessment of needs and planning of care

- The views of patients in the Northampton men's service were not consistently included in care plans.
- In Northampton, generally patients had well written risk assessments and care plans. However on the two male specialised wards for patients with hearing difficulties and those with acquired brain injuries(Fairbairn and Rose), the care plans were very long and were not in a format which would assist patients to understand them.
- Health plans were in place.
- Care programme approach meetings took place.

- In Birmingham people's physical health needs were assessed and monitored to protect their health and wellbeing.

Best practice in treatment and care

- In Northampton, the medication records demonstrated adherence to professional guidance and we noted referrals had been made to specialist services where required.
- In Northampton, Spring Hill house the ward had established a treatment programme based on dialectical behaviour therapy (DBT).
- In Northampton, the provider had worked with the Royal College of Psychiatrists to adapt the Health of the Nation Outcome Scales specifically for service users in secure settings. These are reported to their commissioners in order to meet their contractual obligations.
- In Essex, we found that some staff had difficulty in accessing the electronic care and treatment records used throughout the hospital.
- Outcomes for people were also assessed through use of the health of the nation outcome scales (HoNOS) secure assessment tool. A range of therapeutic interventions in line with National Institute for Health and Care (NICE) took place.
- A quality network for forensic mental health services, peer and self-assessment inspection had taken place on Frinton ward in May 2014 with identified good practice and areas for improvement. We noted that the provider had already taken actions to address an area identified for improvement.
- In Nottingham, NICE guidance informed policies, medication practice and psychological interventions. One ward had introduced the concept of a theraputic community which was being embedded.
- In Nottingham, The hospital provided data for the first quarter that showed only one third of the activity offered to patients was taken up.

Skilled staff to deliver care

- In Northampton, we were told that there were issues around maintaining staff on Fairburn ward who were trained in British sign language (BSL). It often occurred that staff were trained up to a level to work with patients, then moved to work on other wards.
- In Northampton, staff received mandatory training annually which included safeguarding adults, basic life support training and training to ensure that restraint was applied safely when necessary.

- In Essex, staff confirmed that they had received mandatory training and this was confirmed by those records seen.
- In Essex, we found that staff had access to regular supervision and staff had received annual appraisals. We saw examples of additional training being provided for ward based staff
- In Birmingham, people were not consistently supported to participate in regular activities.

Multi-disciplinary and inter-agency team work

- In Essex, we found effective multi-disciplinary working (MDT) within the service to meet people's needs.
- In Nottingham, we found there were good multi displinary team meetings to review care which involved patients and analysed behaviours and incidents.
- In Nottingham, some patients had communication passports.
- In Nottingham, there was an initative called "meaningful conversations" which had been introduced to facilatate dialogue by nurses which patients were postive about.

Adherence to the MHA and MCA Code of Practice

- Generally we found in Northampton that patients were regularly being assisted to understand the rights under the Mental Health Act. However, we found on Fairbairn and Rose wards this was not being consistently recorded. We also found evidence in patient notes of rights being documented as not understood and the next review date being six months ahead.
- In Essex, we saw clear procedures in place regarding the use and implementation of the Mental Health Act and the Mental Health Act code of practice.
- Advocates were available for people throughout the hospital and most people we spoke with told us they were aware of their rights.

Good Practice in applying the MCA

- Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). All staff we spoke with were able to tell us in detail how this related to the patients. In reviewing the care records, we found detailed capacity assessments relating to different aspects of the patients life and care provision. These were reviewed at the weekly team meetings.

Are services caring?
Kindness, dignity, respect and support

Good

Summary of findings

- In Northampton, regular staff were able to articulate individual patient's preferences and daily needs.
- In Essex, most people told us that staff were approachable and they gave them appropriate care and support.
- In Essex, we found that people who used the service were treated with dignity and respect.
- In Essex, staff were caring and compassionate, and they were motivated to make sure that people were well supported
- In Birmingham, all visits to people were supervised by staff which impacted on people's privacy.
- In Nottingham, there was a mixed picture of the way that patients were treated by staff. We observed some staff to be caring and compassionate. We also observed staff swearing in the office and heard that there had been some problems with staff on Rufford ward in particular.
- In Nottingham, not all patients felt their religious and spiritual needs were respected.

The involvement of people in the care they receive

- In Northampton, we saw from patients' records the provider used the my shared pathway (MSP) approach, which is a recovery and outcomes based approach to the planning and delivery of care.
- On Spencer North ward in Northampton, we were invited to attend two care programme approach meetings. Both of these were chaired by the respective patients. During the meeting the patients' electronic record were displayed and any decisions were clearly explained to the patient.
- We found that the men's service were not consistently documenting patients' views in the records or whether attempts had been made to engage people in the process.
- On Rose ward in Northampton patients received an information pack about the ward which included pictures to assist them to understand the content. We saw how this pack was personalised for each person and included information about care reviews, how to complain, the ward activities and names and pictures of their care co-ordinator.
- In Essex, the provider had systems to encourage people to be involved in their assessment, care planning and reviews through use of recovery tools such as 'my shared pathway'. People had the opportunity to attend a hospital based 'service user forum'.
- In Birmingham, most people were involved in their care and treatment plans. However, some people in Speedwell were not always involved in this care as information was not provided in a format they could understand.

Summary of findings

- In Nottingham, out of area placements posed difficulties for friends and families visiting and participating in specific meetings.
- In Nottingham, there was an active patient representative group “our voice” who had formulated an action plan for changes they required. Representatives from the group had participated in training and interviewing.
- In Nottingham, advocacy was available and used although requests for it were not often made in relation to safeguarding issues.

Are services responsive to people's needs?

Good

Access, discharge and bed management

- In Northampton, we saw that all patients had a discharge plan except those on Cranford and Robinson wards. However, there were sometimes delays in discharges when people moved back to their home areas due to the availability of appropriate facilities.
- In Northampton, on Hereward Wake and Spring Hill house both patients and staff we spoke with told us they were concerned about the impact on care pathways as a result of changes to commissioning arrangements. This would mean when patients were ready for discharge they may not be able to access the local step down facilities as these would no longer be funded.
- In Nottingham, we reviewed case notes and found that discharge planning was included in care plans involving the person, family and agencies.
- In Birmingham, staff worked with community teams to plan people’s discharge from hospital

The ward environment optimises recovery, comfort and dignity

- In Northampton, 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.
- Patients on Grafton ward had moved from a ward with ensuite facilities and outdoor space to a ward that did not have these.
- In Birmingham, wards were generally comfortable. However some improvements could be made.

Ward policies and procedures minimise restrictions

- In Northampton, blanket restrictions were in evidence on each ward we visited such as no patient internet access and doors being locked during the day. There were practices on some wards designed to facilitate patients attending groups such as bedroom doors being locked during activity sessions.
- In Nottingham, we observed that patients were able to personalise their bedrooms, on Thorsby ward they had also decorated the de-escalation room.
- In Birmingham all people were searched on return from leave regardless of their assessed risks.

Meeting the needs of all people who use the service

- In Birmingham, we found the service met people's religious and gender-specific needs.
- In Birmingham, staff had access to good interpreting services. This meant that people could communicate their needs effectively, and staff knew how to respond.
- In Essex, we saw evidence in people's care and treatment records of how the service had reviewed and amended treatments in order to meet their changing assessed needs. We reviewed some good examples of responsive care during the inspection.
- In Essex, a quality network for forensic mental health services, peer and self-assessment inspection had taken place on Frinton ward in May 2014 with identified good practice and areas for improvement. We noted that the provider had already taken actions to address an area identified for improvement.
- People's physical health needs were being appropriately monitored with regular checks completed.
- Chaplaincy information was displayed on wards.
- In Essex there was evidence of site developments to respond to people's assessed needs. However there were not consistent systems for staff to respond to and meet people's diverse cultural and language needs on Frinton ward.

Listening to and learning from concerns and complaints

- In Northampton, several patients told us they waited to speak to regular staff as they questioned the knowledge of the bureau staff.
- In Northampton, each ward had a book dedicated to learning from incidents and complaints generated across the hospital site. This ensured learning not just from their own ward but from other services. We saw action plans arising from complaints and the resultant changes on the wards.
- 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.
- Patients told us they were not satisfied with the complaint process in the learning disability and CAMHS services. They feel their complaints were rarely fully addressed and often do not receive a clear response.
- In Birmingham, we found that concerns or complaints were dealt with and improvements made where needed.
- In Essex, information about how to make a complaint was clearly displayed on the ward noticeboards for people to read. People told us that they felt well supported by staff in making complaints.
- In Essex, complaints and concerns raised were discussed at the monthly 'patient safety and experience group' meeting to ensure that actions were completed and responses and feedback sent to people in a timely manner.

Are services well-led?

Requires Improvement

Vision and values

- In Northampton, most staff were aware of the senior management within the provider. However, some staff told us that they felt there was a disconnect between the executive team and the teams on the wards.
- In Nottingham, patients who used services did not consider that ward leaders were visible.
- The staff were aware of the providers' board members, but were not clear about the providers' strategic direction.
- In Essex, we found that the provider provided information to staff and people about their service in different and effective ways. Most staff were aware of the provider's core values.

Good governance

- In Northampton, the service had regular ward manager meetings weekly. Information in these meetings was collated and fed into meetings at ward level.
- In Northampton, there was a divisional quality and compliance meeting which met to feedback and ensure learning across the service and this fed into the quality and compliance meeting across the provider.
- In Northampton, there were separate 'lessons learnt' meetings following incidents and the information from these meetings was fed back at ward level. These meetings ensured that quality

at ward level was monitored. The ward managers had a good understanding of the risks on the wards and within the service which meant that information was shared and promoted learning.

- In Nottingham, supervision was provided however was not consistent. We observed a reflective practice session which was led by a psychologist this had been implemented to make improvements.
- In Nottingham, appraisals were provided annually for all staff with a high level of compliance.
- In Nottingham, mandatory training compliance was monitored monthly and 91% was achieved for June 2014.
- In Birmingham the hospital's medicine management policies were not followed by pharmacy staff.
- In Birmingham, people's personal information was not always kept confidential and handled correctly.
- The provider had a governance framework in place in Essex with links for feedback to/from the central site at Northampton. For example we noted that 'out of hours' visits by senior staff and unannounced visits from directors took place with reports on the quality and experience of care provided.

Leadership, morale and staff engagement

- In Northampton, ward staff in the forensic services spoke highly of the multi-disciplinary team.
- In Northampton, some staff in forensic services were concerned about the long term impact of the organisation's project to upgrade wards to meet the standards required.
- In Birmingham, staff were generally well supported by their managers and by the senior management. Staff in Speedwell ward were not supported to take their breaks. There were insufficient occupational therapy staff which led to some staff feeling unsupported.
- In Essex most staff reported support from their manager. They told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. Most staff reported managers were approachable and they were effective leaders.
- We noted that there were no unit managers in place for Danbury and Frinton wards at the Essex location.

Commitment to quality improvement and innovation

Summary of findings

- In Northampton, most staff had a good understanding of the performance of the ward within the provider.The ward management teams had strong plans focusing on improvement.
- In Birmingham, people who used the service were listened to and, as a result, improvements made.
- In Essex, people and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys.

Summary of findings

Background to the service

St Andrew's Healthcare is a charity providing specialist mental health care. It was established 176 years ago. The charity provides services for adolescents and young adults, women and men of working age and older people, with a thousand inpatient beds. Additionally it provides community and in-reach services, private therapy services for GP-referred patients and medico-legal expertise.

St Andrew's Healthcare Northampton is the St Andrew's headquarters and home to adolescent mental health, the national secure service for women, learning disability, brain injury and the charity's research team.

St Andrew's Healthcare Essex is a low secure hospital located in North Benfleet, Essex. The hospital is registered to accommodate 92 adults who have mental illness and can be detained under the Mental Health Act 1983. Accommodation is on the ground and first floors. There is a separate step down unit, which was completed in April 2009.

The core services provided at this location were secure and forensic services and a psychiatric intensive care unit (PICU). We noted that the provider was refurbishing this location and in the meantime only six out of the seven wards at this location were being used.

St Andrew's Healthcare Birmingham is an independent hospital which provides medium and low secure care for people with mental health problems and / or autistic spectrum conditions. The hospital is registered to accommodate up to 128 people and is made up of eight wards. There is one ward, Moor Green, which is for women only.

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 higher 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 from across the United Kingdom. The centre consists of four wards, Thorsby ward 14 bedded medium secure unit, Wollerton ward 16 bedded medium secure unit, Rufford ward 18 bedded low secure rehabilitation and recovery unit, Newstead ward 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 included CQC inspectors and a variety of specialists:

The team that inspected these services consisted of CQC inspectors, Mental Health Act reviewers, consultant psychiatrist, nurses, psychologists, researchers in mental health, social workers and experts by experience who were people who had previously used mental health services.

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 held about the provider and asked other organisations to share what they knew. During the inspection we held focus groups with a range of staff, such as nurses and doctors. We talked with people who used services who shared their views and experiences. We talked with staff at each location. We observed how people were being cared for and talked with carers and family members. We reviewed care and treatment records.

During our inspection at the Northampton location we:

- Spoke with 52 staff.
- Spoke with 36 patients.
- Looked at 52 sets of patient records along with the associated Mental Health Act paperwork.
- Reviewed 78 medication records and consent to treatment documentation.
- Attended a number of care meetings, multi-disciplinary meetings and community meetings.

During our inspection at the Essex location we:

- Spoke with 13 patients.
- Spoke with 41 staff.
- Reviewed 15 sets of care records.
- Observed two multi-disciplinary team meetings.

During our inspection at the Birmingham location, we :

- Spoke with 48 staff (including bureau staff, and allied professionals).
- Spoke with 23 patients.
- Reviewed12 sets of medication records.
- Reviewed 13 sets of care records.

During our inspection at the Nottingham location we:

- Spoke to 25 patients.
- Reviewed 39 sets of case records.
- Reviewed medication charts.
- Observed a night staff handover to day staff.
- Observed a therapeutic community meeting.
- Observed a community meeting.
- Held a patients representative focus group.
- Held a social worker focus group.
- Spoke to staff including ward managers, consultant psychiatrists, professions allied to medicine, ward administrators, financial assistant, health care support workers, psychologists, occupational therapists.

What people who use the provider's services say

Northampton Site:

Generally the patients in the women's service we spoke with were very positive about the care which they received on the ward. However some did tell us they felt unsafe at times when the wards were disturbed.

Birmingham Site:

Patients told us they felt safe at the hospital and their bedrooms were cleaned every day and that the ward was always clean. People told us they could personalise their bedrooms. People told us that sometimes they got bored as there was not enough staff to support them to do regular activities. Some people told us they did not like the food. However, other people told us they enjoyed the food provided. Several people told us that they had not agreed with their plans about controlling their weight.

People told us that seclusion was not often used. They thought this was good as they had been in seclusion in other hospitals they had been in.

People told us that the staff were good and respected them. People told us that all visits were supervised and could not always see why this was needed.

Nottingham Site:

Summary of findings

A patient satisfaction survey was carried out in April 2014 by the hospital. 25% of respondents rated services in Nottingham as excellent and 60% between fair and very good, 15% as poor. The results for the hospital showed that staff made patients welcome on arrival to the ward. The wards were rated as amber overall which meant over 75% of patients responding were satisfied in relation to being introduced to the ward and routines, food, cleanliness and noise at night. Patients felt that nurses listened to them carefully. The wards were rated as amber in relation to how other staff listened and treated patients with respect and dignity. 59% of patients spent between 30 to 90 minutes with their care coordinator, the remainder of patients did not know how much time was spent with the care co coordinator. The hospital was rated as amber for care and treatment, however were rated red for activities. 93% of patients felt their spiritual needs were addressed.

Most patients told us there are some kind and helpful staff. All patients using services except for two told us there were too few staff to meet their needs. They told us this affected their experience, as it led to incidents, affected their ability to have section 17 leave, access to activities, privacy and dignity.

Not all patients knew who their named nurse was. There had been numerous changes in responsible clinicians due to turnover which patients did not feel comfortable with.

Patients informed us that the food and portion sizes were not good; sometimes menus were misplaced causing confusion over dietary needs.

"Our voice" patient representative's focus group reported that ward managers were not visible and there was not enough nurse led activities. The group stated that generally patients did not feel safe. Whilst patients understood the safeguarding process, they were frustrated by the length of time it took to receive the outcome of the safeguarding.

There were mixed views about the effectiveness of the ward community meetings, some patient representatives reported that the meetings helped in discussing incidents in the context of a therapeutic community and others found the community meetings too dictatorial. The focus group reported that the "meaningful conversation initiative" was good.

We found instances where the Mental Health Act code of practice was not adhered to.

Essex Site:

We spoke with patients through focus groups, attendance at community meetings, service user forum meetings and individual conversations with people. We reviewed the provider's quality monitoring systems such as surveys and monthly business continuity meeting minutes.

People told us they usually felt safe on the wards and had good care. They said most staff listened to them and were good at defusing situations which helped them to feel safe.

We reviewed the results of a recent survey carried out on Danbury ward. Many of the comments seen were positive but some people requested more consistent staff and activity provision.

Most people told the inspection teams that staff were caring and understood them. They said that this helped them to trust the staff. Some people told us that activities that they enjoyed were offered. Whilst others told us that they wanted a wider range of activities provided.

Some people had concerns about accessing section 17 leave and felt that they were disadvantaged by some people requiring more staff time and attention due to the acuteness of their illness.

Good practice

Northampton Site:

- Staff across the service showed knowledge of the patient's needs.
- All paperwork was of high standard including that for the Mental Health Act.
- Reviews of care within the multi-disciplinary team was thorough.

Summary of findings

- Mental capacity was assessed regularly.
- Within the women's service, the documentation of restraint and seclusion was detailed with timings and we saw learning from incidents had occurred.

Birmingham Site:

- One person in Hawkesley ward was studying for a Masters degree. The hospital had supported them to get a laptop, which helped them in their studies.
- Patients in Northfield ward were supported to access community based college courses and work placements.
- We saw good examples on wards in Birmingham of how individual patients were treated to help them as part of their rehabilitation into more community-based living.
- Each ward had at least one 'buddy'. This was a patient and they showed others around the ward on admission which helped them to feel safe.
- Patients were involved in recruiting new staff.
- Staff on wards at Birmingham showed a good knowledge of individual patients, individual risks concerning those patients and how they were most effectively managed.

Essex Site:

- We found good examples of effective cognitive behaviour therapy taking place with individuals.
- We observed and staff reported good and supportive multi-disciplinary team working.
- Robust systems were in place for the management and auditing of medicines.
- We found that the monthly patient safety and experience group was an effective forum for managing and learning from patient safety incidents that took place in the hospital.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Northampton Site

Action the provider MUST take to improve

- The men's Service must ensure that all patients have a discharge plan in place.
- The service must ensure that patients' views are documented in care plans.
- Fairbairn ward must ensure that there are enough suitably skilled staff retained on the ward to ensure communication between staff and patients. This includes the ability to request staff trained in British sign language.
- Sitwell ward must ensure that reviews of patients being restrained and secluded are undertaken and documented fully.
- Fairbairn and Rose wards must ensure that patients are assisted to understand their rights.
- Seacole ward must ensure that medication administration is accurately recorded.

Birmingham Site

Action the provider MUST take to improve

- The provider must ensure that all staff follow safe medicine management policies.
- The provider must ensure that systems are in place to ensure that the relevant staff are aware of people's blood monitoring results so that they can safely prescribe people's medicines.
- The provider must ensure that all nursing staff are informed of the outcomes of investigation following the reporting of medicine errors.

Action the provider SHOULD take to improve

- The provider should ensure that all food in the hospital is stored safely.
- The provider should make sure that all staff are able to take their breaks.
- The provider should make sure that all seclusion rooms are safe for people to use.
- The provider should make sure that more staff are trained to use the gym so they can safely support people who use the service.
- The provider should make sure that information about people's care and treatment is provided in a format that each person who uses the service can understand.

Summary of findings

- The provider should make sure that all wards are comfortable to promote the wellbeing of people who use the service.
- The provider should make sure that systems are in place to ensure that when the ward manager is absent, action can still be taken to make improvements to benefit people who use the service.
- The provider should ensure that people who may not have capacity to make decisions are assessed as required to ensure that the appropriate safeguards are in place.
- The current independent mental health advocacy (IMHA) service should be reviewed to ensure that all people who use the service can access this service if they choose to.
- The provider should review the layout of Speedwell ward.
- It should be clear in people's records why some people had regular unescorted access in the community but could not go out in the garden when they wanted to.
- The provider should review the policy of supervised visits for all people who use the service.

Nottingham Site:

Action the provider MUST take to improve

- The provider must ensure that there is adequate skill mix and deployment of staff to meet the therapeutic needs of patients who use services.
- The provider must ensure adherence to the Mental Health Act code of practice by ensuring current responsible clinicians document the capacity and consent, document the outcome of SOAD reviews of treatment, and that statutory consultees record their discussion with the SOAD. People using services must be provided with a copy of their section 17 forms and leave facilitated. Searches must take into account individual risk and consent.

Action the provider SHOULD take to improve

- The provider should ensure patients know who their named nurse and care coordinator is and regular meetings take place.
- The provider should ensure the ward leadership is visible to patients.
- The provider should ensure that there are no blind spots in the seclusion rooms and bedrooms.
- The provider should ensure that ward staff only use acceptable language and behaviours.
- The provider should ensure that patients are fully engaged in planned activities

Essex Site:

Action the provider MUST take to improve

- The trust must ensure that the ligature risks identified on Audley ward are risk assessed and addressed.
- The trust must ensure that all assessment and treatment records for people who use Maldon ward are accurate and fit for purpose.

Action the provider SHOULD take to improve

- The provider should ensure that the current refurbishment programme addresses the blind spot identified on the seclusion room on Audley ward.
- The provider should ensure that emergency resuscitation drills take place as part of ongoing staff training.
- The provider should review the effectiveness of their current staff recruitment and retention policy and procedures.
- The provider should ensure that the maintenance issues identified around the hospital's drainage system and excessively warm ward areas are addressed effectively for the comfort of people and staff.
- The provider should ensure that all staff have appropriate access to those electronic care and treatment records that they require to effectively do their job.
- The provider should review the current practice of blanket restrictions within this location. For example the locking of patient bedroom corridors at specific times.
- The provider should review the systems in place on Frinton ward for staff to respond to and meet people's diverse cultural and language needs.
- The provider should ensure that recruitment takes place to ensure that ward managers for Frinton ward and Danbury ward are appointed.
- The provider should ensure that every action plan detailing their response to direct people's feedback are available on the unit.

St Andrews Healthcare

Long stay/forensic/secure services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
St Andrew's Healthcare – Men's Service	New Grafton Ward Fairbairn Ward Rose Ward Robinson Ward Cranford Ward Foster Ward
St Andrew's Healthcare – Women's Service	Thornton Ward Sitwell Ward Seacole Ward Sunley Ward Spencer North Ward Spring Hill House Hereward Wake Ward
St Andrew's Healthcare Birmingham	Northfield Hawkesley Speedwell Edgbaston Hazelwell Moor Green Lifford Hurst
St Andrew's Healthcare Essex	Frinton Maldon Danby Hadleigh Colne

Detailed findings

	Audley Easton Lodge
St Andrew's Healthcare Nottingham	Thorsby Wollerton Newstead Rufford

Mental Health Act responsibilities

Northampton Site:

Mental Health Act paperwork was accurate and complete in all sections. Consent to treatment forms were attached to the medication forms as required.

Birmingham Site:

We saw that people who were detained there under the Mental Health Act (MHA) had the appropriate documentation in place for consenting to their treatment including medicines. Where people had been prescribed treatment without their consent, because they did not have the mental capacity to do so, or had refused to, we saw that a second opinion appointed doctor (SOAD) had seen them and stated that it was appropriate for treatment to be given.

Records we sampled showed that people's forms for when they had section 17 leave from the ward had been completed appropriately. These included a risk assessment completed before the person went on leave to ensure their safety and wellbeing.

We saw that the checklist that staff used for informing people of their rights had two of these rights missing. These were the right to see the MHA code of practice and access to an Independent Mental Health Advocate (IMHA). This could mean that people were not aware of these and we found that few people who used the service accessed the IMHA.

Records we sampled showed that staff had attempted to explain to people their rights under the MHA. However, six records we sampled showed that the person had refused this but staff had recorded that the person had understood their rights. This could mean that staff might not make further attempts to explain these to ensure that people are aware of their rights. Another record stated that the person did not understand their rights, however, no further attempts were made to explain these to the person.

Nottingham Site:

There were systems in place to scrutinise detention papers to make sure they followed the Mental Health Act (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. We found no evidence of repeated attempts when patients refused or were unable to understand their rights. Patients had access to an independent mental health advocate (IMHA) and used them.

Case notes demonstrated and patients using services confirmed that hospital manager's hearings and mental health review tribunals took place.

We found some good documentation confirming mental 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 code of practice Mental Health Act 1983 not all case notes confirmed that patients had been informed by the responsible clinician of the outcome of a second opinion appointed doctors visit (SOAD) nor had the statutory consultees recorded their discussion with the SOAD. This means that patients were not aware of the outcome of the independent review of their treatment plan.

Detailed findings

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 code of practice. There was no record of patients being given copies of section 17 leave forms and patients said they had not received copies.

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

We observed that staff had access to the copies of the Mental Health Act and code of practice

Essex Site:

We found that staff in this core service were aware of their duties under the Mental Health Act (1983). Staff had received the relevant mandatory training.

The records we saw relating to the Mental Health Act were generally well kept and any concerns identified were shared with front line staff during our inspection. The rights of the informal person were being protected on one ward and this was well recorded.

Mental Capacity Act and Deprivation of Liberty Safeguards

Northampton Site:

Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). All staff we spoke with were able to tell us in detail how this related to the patients. In reviewing the care records, we found detailed mental capacity assessments relating to different aspects of the patients life and care provision. These were reviewed at the weekly team meetings.

Nottingham Site:

We found records of multi-disciplinary discussions about mental capacity in relation to holistic patient care. However we did not find evidence that these were recorded as best interest decisions. The advocate and social work team confirmed these discussions did take place and gave an example of a best interests' assessment meeting that was planned to take place. Training in relation to MCA and Dols was provided to staff on induction.

Essex Site:

Most the people who used this core service were currently detained under the 1983 Mental Health Act. People's mental capacity to consent to their care and treatment had been assessed. Those assessment and treatment records showed us that where people had been assessed as not having the mental capacity to consent to their care and treatment, decisions about this were made in their best interests.

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

Safe and clean ward environment

- In Northampton, the design and layout of some wards made lines of sight difficult.
- In Northampton, we found ligature risk and environment audits were undertaken every six months. We saw that some ligature risks had been identified and there were contingency plans in place to manage these.
- The clinic rooms were fully equipped and resuscitation equipment was checked regularly and recorded.
- In Northampton, all the wards of the male forensic service were generally unclean. Wards in William Wake House showed a better state of cleanliness, however the wards and furniture were still not as clean as they should have been.
- In Essex, we found that the wards were clean and staff practised safe infection control procedures to minimise the risk of cross-infection.
- In Nottingham the environment was clean;
- We found blind spots in the seclusion rooms and bedrooms in Nottingham.
- In Birmingham, we found that systems were not in place in the kitchen used by the people in Northfield ward to ensure that food was safely stored.
- In Nottingham, we found that the resuscitation equipment was not checked on a weekly basis as required.
- In Birmingham the seclusion room in Northfield was not safe at the time of our inspection, but was made safe following this. In Edgbaston ward the seclusion room intercom was not clear so that people using this were not able to hear staff and summon assistance if needed.

Safe staffing

- The Trust staff booking system allowed for special requests to be entered such as staff trained in Bristsh Sign Language. However, Fairbairn Ward management in Northampton were unaware of this fact and highlighted the risk as a result that, although the ward had an interpreter available at least 10 hours every day, this still resulted in periods when patients' were not able to communicate effectively with staff who were allocated to their wards.
- In Northampton, some agency staff and some bureau staff did not have access to the electronic notes system.
- In Essex, systems were in place to ensure adequate staffing and skill mix. For example, we found that the provider used a recognised tool for identifying people's dependency needs and the level of staffing required. Nursing staff rotas were planned four weeks ahead. However some concerns were identified across this location about the high use of bureau and agency staff on the wards.
- In Nottingham we were told by staff and patients that they were concerned about staffing. These were that the staffing skill mix and deployment had an affected on the patient experience.
- There were enough staff to provide safe care. The number of staff was increased to meet people's needs and ensure their safety. However, we found in Speedwell ward that most staff did not take their breaks which could impact on people's safety.

Assessing and managing risk to patients and staff

- In Northampton, Sitwell ward was not consistently documenting patients' review of restraint.
- In Northampton, Sitwell ward was not following St Andrew's seclusion policy with regard to seclusion reviews with patients
- On Seacole Ward, there were errors in the recording of medication administration.
- In Essex, staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort
- In Essex, staff undertook risk assessments. Management plans were available for people and the environment to keep them and others safe.

Requires improvement

Are services safe?

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

- In Essex, staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort.
- In Essex, we found that improvements were required as the services provided were not always safe. Actions from ligature audits were not followed through on one ward and care and treatment records were incomplete in respect of one person's physical healthcare needs. This meant that people may be at risk of unsafe care and treatment.
- In Nottingham, we found that the resuscitation equipment was not checked on a weekly basis as required.
- In Nottingham, we observed handover of care being given between shifts. We saw that these were too short and there was little meaningful information shared.
- Staff and patients understood the safeguarding processes. Patients were concerned that feedback on the outcome took too long.
- In Birmingham, we found that medicines were managed safely on the wards. However, we found that medicines in the pharmacy were not stored and disposed of safely.
- In Birmingham, systems were not in place to ensure that staff had the information needed from people's blood test results to ensure that the correct dose of medication was prescribed.
- In Birmingham, staff had received safeguarding training and demonstrated that they knew how to protect people from harm.
- In Birmingham, staff were trained in managing violence and aggression. We found that restraint was used safely and only as a last resort.

Reporting incidents and learning from them when things go wrong

- Staff we spoke with had a good understanding of the reporting system. The provider used a 'Datix' system to report incidents which ensured that ward managers were aware of all the incidents which were reported.
- Staff told us they had access to support through debriefing after incidents but this was not always formal.
- There was an incident folder available on the wards in a staff area. Staff who were not able to attend meetings had sight of minutes and were asked to sign to ensure that they had read them.
- In Essex we found staff reported any incidents/ accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.
- In Nottingham we found there were systems and processes to monitor staffing, incidents and safeguarding, which were summarised in a ward dashboard.

Our findings

Northampton Site

Safe and clean ward environment

There were some areas within the wards where there was poor visibility. This was managed through staff observations and knowledge of the patients. There were ligature audits throughout the service which were undertaken annually. We saw that some ligature risks had been identified and there were contingency plans in place to manage these within the context of the group of patients on the ward. There were some rooms available which were better adapted to people who were at higher risk of self-harm.

There was a perimeter check of the ward environment on a daily basis and every month bedroom audits were undertaken to ensure that any environmental issues were reported. All the wards of the male service were generally unclean. The wards were hot and felt stuffy. The women's service wards were of a higher standard however patients still told us they wished their surroundings were cleaner.

The clinic rooms where medication was stored were clean. Most wards in the service had resuscitation equipment available and we noted it was monitored regularly. However, Grafton ward's lifesaving equipment was shared with another ward on the same site.

Not all wards had a seclusion facility available for use. Grafton and Hereward Wake wards did not have a seclusion

Requires improvement

Are services safe?

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room. On Hereward Wake, this meant that patients requiring seclusion were being transported to a different location by secure transport. We heard on rare occasions, the transport was unavailable leaving both the staff and patient at risk.

Sitwell ward had a seclusion room. This was not available due to the area being used to nurse a patient in long term segregation. Patients requiring seclusion were therefore taken to another ward within the same building. We had concerns about the maintenance of that patient's dignity and the potential distress caused to other patients who may have witnessed this. Indeed, patients told us this was of concern to them.

We had concerns regarding Fairbairn ward's seclusion room. The room was monitored by CCTV. There were areas of the main room and bathroom which remained not visible to staff. There was an intercom system installed which would be of no use for non-hearing staff. The observation window in the door was inadequate for signing as agreed by the organisation. We highlighted these issues to management who met to resolve this during our inspection.

Safe staffing

Staff told us that few agency staff were used and that, when additional staff were needed to carry out observations, these staff were provided from the bureau. We were told that agency staff and some bureau staff did not have access to the electronic notes system.

There were always qualified staff on duty, a range of allied health professionals and medical staff. At night across the whole site there are permanent night staff and on call cover divided by directorate.

Ward managers we spoke with told us they could access extra or replacement staff via the provider's staff bureau via the online management system. They were able to ask for regular staff who knew the ward and patients to enable consistency.

The Trust staff booking system allowed for special requests to be entered such as staff trained in Bristsh Sign Language. However, Fairbairn Ward management in Northampton were unaware of this fact and highlighted the risk as a result that, although the ward had an interpreter available at least 10 hours every day, this still resulted in periods when patients' were not able to communicate effectively with staff who were allocated to their wards

Staff consistently spoke of being understaffed. The rotas did not support this. The numbers were made up to compliment by bank or agency staff. However, we found that over 150 hours of activities had been cancelled in August 2014 stating the reason as lack of staff. This would suggest that the issue lay rather with the deployment and usage of the staff on shift rather than numbers.

Assessing and managing risk to patients and staff

Staff on the ward had a good understanding of the safeguarding audit processes. The care records we looked at showed that risk assessments were clear, reflected the needs of patients and were up to date. We checked the medication and clinic room on the wards and found the records were up to date and medicines were appropriately recorded and stored. However on Seacole ward, we found errors in recording including a missed signature on a prescription chart.

The seclusion policy had been followed correctly including observation of the patient, medical and nursing reviews and documentation. However, on Sitwell ward we found that post seclusion reviews were not consistently documented as required by the Mental Health Act code of practice.

Some patients were prescribed medication to help with extreme episodes of agitation and anxiety. These medicines were prescribed to be given only when other calming techniques had been used by staff. This is known as rapid tranquillization. Arrangements were in place to provide guidance to medical and nursing staff for this treatment. We found patients were physically checked for their own safety following administration of medicines for rapid tranquillisation.

Reporting incidents and learning from them when things go wrong

Staff we spoke with had a good understanding of the reporting system. The provider used a 'Datix' system to report incidents which ensured that ward managers were aware of all the incidents which were reported. Staff told us they had access to support through debriefing after incidents but this was not always a formal process.

Requires improvement

Are services safe?

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

The wards had regular meetings where information was disseminated about incidents both on the ward and across the service. There were incident folders available on the wards in staff areas. Staff who were not able to attend meetings could view these minutes and were asked to sign to ensure that they had read them.

The service had an additional 'lessons learnt' update which was sent to wards within the service to ensure that learning took place across the service and across the provider.

We spoke with the ward manager on Grafton ward who gave us examples of how incidents had led to learning on the ward. For example, one incident where a person on the ward had needed additional support regarding physical healthcare needs had led to an adaptation of intermediate life support (ILS) training to incorporate their specific needs.

All permanent staff we spoke with said they would be confident to report any safeguarding issues. They demonstrated an understanding of the types of situation which would require a formal referral. We reviewed a recent safeguarding incident on Sunley ward which had been reported by ward staff to the local authority and saw the comprehensive investigation. This had concluded the incident was unfounded and no further action was required.

Birmingham Site

Safe and clean ward environment

We observed that staff were able to observe all parts of the wards to ensure the safety of people who used the service. In Northfield ward there were some areas that could not be clearly seen from the office windows. Therefore, mirrors were provided in these areas so that staff could observe all parts of the ward and ensure that people who used the service were safe.

We saw that there were no ligature points around the wards, which helped to ensure people's safety. Audits of ligature points were completed annually. Staff told us these would be done more often if changes were made to the environment to ensure that all risks were reduced.

Staff told us that the emergency bag held on Edgbaston ward was used when needed for two other wards: Hawkesley and Hazelwell. Hawkesley was opposite Edgbaston ward. However, Hazelwell was in another building. Staff told us that it would take a minute to get there in an emergency although they had not tested this for a few years. We discussed this with the Hospital Director and by the end of this inspection, an emergency bag had been purchased for use on Hazelwell ward. We saw that the emergency bag was tested weekly to ensure that all equipment was safe to use.

In all wards but Northfield, the seclusion room allowed clear observation, had toilet facilities and a clock that displayed the correct time. In Northfield ward there was no mattress and the room was very cold. If a person was using the toilet in the seclusion room or was sitting behind the toilet door that it was not possible for staff to observe them. This could put the person at risk of harm. Staff told us that as it was a low secure ward, this room would rarely be used and had not been used since the ward was refurbished in July 2014. We raised our concerns with the Hospital Director that people's safety would be at risk when using this room. They responded and ensured that by the next day a mattress and a mirror were provided. They also planned to have a camera installed so that staff would be able to view the person in all areas of the room to ensure their safety.

In Edgbaston ward there was not an intercom inside the seclusion room but people would have to summon staff assistance by going to the window. This could put people at risk of harm. There was no mattress on the bed in the extra care area that was next to the seclusion room. We saw that this room was ready for use if needed and staff said it was used. They told us that they would ensure a mattress was provided.

The wards were clean. People who used the service told us this was usual. During our visit the housekeeper supervisors visited some wards to undertake an audit of the ward cleanliness and maintenance. They told us they completed these audits every three months to ensure that the ward was clean and well maintained. However on Edgbaston ward some people told us that the chairs were not cleaned regularly and we saw that these were stained. People also told us that there were no wipes to clean the pay phone after each use, which would help to minimise the risk of cross infection.

We saw that regular health and safety checks were completed. On each shift one member of staff was allocated to the 'safety nurse' role. This meant that they checked all ward areas and the perimeter fences and ensured that all visitors were aware of safety procedures to

follow. Staff told us that they received training to undertake this role and then had to shadow another staff member at least three times to show they were competent to carry out the role.

A kitchen was provided in Northfield ward that people who used the service had access to. This was used for people to do their own cooking and make their own drinks. We found that there was no member of staff allocated as responsible to check the fridge contents and dispose of any out of date food. We saw that food stored in the fridge was labelled as to what it was but not the date on which it was opened, so it was not clear when it needed to be used by. The temperature of the fridge was not checked to ensure it was at a safe temperature to store food. This could pose a risk to the safety of people who used the service.

In Speedwell ward staff and people who used the service raised concerns about the number of people on the ward. There were 17 people on the day of our inspection and there could be 18 people admitted at one time. The ward is for people who have an autistic spectrum condition who may find being in large groups difficult. This could lead to people becoming anxious which could compromise their safety and wellbeing.

Safe staffing

Staff we spoke with told us that staffing levels had been set according to the needs of the ward to ensure the safety of people who used the service. Rotas we sampled confirmed this. We found that there was a mix of qualified and unqualified nurses to ensure staff had the skills and experience to keep people safe. Staffing levels were generally safe during our inspection. However, in Speedwell ward we saw in staff rotas for August 2014 that on five days there had been two qualified nurses and three unqualified nurses on duty, this was less staff than required. This meant that there were two less unqualified nurses than there should be to ensure the safety of people who used the service. Staff told us that there were always two qualified nurses on each shift. Staff spoken with told us they were stressed and often missed their breaks because there were not enough staff. Staff told us that people who used the service did not have activities or their leave cancelled as they did not take their breaks. The Hospital Director told us that each day staffing levels across the hospital were reviewed. However, the ward manager had refused staff to work on the ward as they had said that unfamiliar staff could unsettle people who used the service due to their autism. The ward manager confirmed that staff often did not take breaks and neither did they. Staff worked 12 hour shifts so without a break this could increase the risk of harm to staff and people who used the service.

Staff told us that extra staffing was provided when needed to ensure that people were supported to attend appointments or have extra observation if unwell. This was confirmed by rotas we looked at.

Rotas showed that bank staff were used to fill the gaps because of staff vacancies or sickness. Bank staff told us that they worked on the ward regularly and knew how to safely support the people who used the service. Bank staff we spoke with showed a good knowledge of individual patient needs and how to meet them. They told us they had received an induction and the training they needed to safely support people. Staff told us, and records showed, that all staff, including bank staff, received regular clinical supervision and were well supported.

Several people told us that activities and leave off the ward were often cancelled due to staff shortages. We saw and staff told us that sometimes leave was postponed but not cancelled. However, staff recognised that this could have a detrimental impact on the wellbeing of people who used the service.

Assessing and managing risk to patients and staff

Records we sampled showed that risk assessments were completed when a person was admitted to the ward. We saw that staff completed risk assessments before a person had leave off the ward and when using the garden.

Staff told us that they were aware of the observation policies and had received these during their induction. One ward manager told us that procedures were implemented, where needed, to ensure that people were not kept on constant close observations longer than needed to ensure their privacy.

Staff and people who used the service told us that restraint was rarely used on the wards. We checked restraint records on Hurst ward and found, in line with what staff told us, the most recent restraint had been carried out over two months ago.

Staff told us that they reduced the risks of needing to use restraint by ensuring staff were available to support people. They also said that people who used the service were offered regular one to one sessions with staff to talk about

how they were feeling and de-escalate any behaviours that could be a risk to people's safety. We saw in records sampled that detailed plans were in place that stated how a person would be restrained if needed. This included the person's physical health needs to ensure they were not at risk when being restrained. All staff received training in managing violence and aggression. This was updated yearly to ensure staff had the skills and knowledge to keep people safe.

We saw and staff told us that rapid tranquillisation was not used on most wards. In Edgbaston ward, some people were prescribed medicines to help with extreme episodes of agitation and anxiety. These medicines were prescribed to be given only when other calming techniques had been used by staff. The ward manager said, "we look at all other causes for the person's behaviour, medicine is not the first answer here." Arrangements were in place to provide guidance to medical and nursing staff for using rapid tranquillisation. We found people were physically checked for their own safety following administration of medicines for rapid tranquillisation and this was recorded in their care records.

People who used the service and staff told us that seclusion was not often used. One person in Edgbaston ward told us, "the last thing they want to do here is seclude people, I haven't been secluded since I've been here but I have been in other hospitals." Records sampled included a plan called 'what works for me to avoid seclusion.' We saw that when seclusion was used, there were clear records kept that ensured the safety and wellbeing of the person who used the service. The person's risk assessment was updated following the seclusion to ensure their safety and that of others.

Staff demonstrated that they knew how to make a safeguarding alert. We saw that staff had made a safeguarding alert when appropriate to ensure that people who used the service were safeguarded from harm. Staff told us and records showed that all staff received training in safeguarding vulnerable adults from abuse. This training was updated yearly to refresh staff knowledge and ensured the safety of people who used the service.

We found that medicines were stored and managed safely on the wards. We saw records that showed medicines were kept at suitable temperatures. However, we found that a large number of controlled drugs (CDs) which were no longer required were stored in the pharmacy. CDs are medicines that require extra checks including special storage, recording and disposal arrangements. The provider had not followed their own controlled drugs procedure, dated June 2014, regarding regular disposal of CDs to prevent the build-up of supply.

Some people were prescribed medicines that required regular blood tests to ensure these were given at a level to improve the person's health and wellbeing. We found that there was no central log of the results of these held at the pharmacy to ensure that where there were concerns these could be followed up. The follow up was reliant on the person's doctor and so this might not be done if the doctor was absent.

Medicines were not stored securely to protect people who used the service. We found the pharmacy room which stored medicines was not locked. We also found that the available medicine storage cupboards in the pharmacy did not meet safe medicine storage requirements or follow the hospital's own medicine management policy dated February 2014.

Reporting incidents and learning from when things go wrong

Staff that we spoke to were aware of when to report an incident. We saw that incidents had been reported appropriately. Staff told us that following an incident they reflected on how they had responded to it and what they could do better. This meant that staff learnt from incidents to ensure their safety and that of people who used the service.

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 the safety of people who used the service.

Nottingham Site

Safe and clean ward environment

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.

Requires improvement

Are services safe?

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

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. The ones provided for review were dated 2013, 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 ensuite 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

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.

Requires improvement

Are services safe?

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

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 patient 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 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

Requires improvement

Are services safe?

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

We saw that each ward received a dashboard statement each month displaying the number of safeguarding alerts, incidents, 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 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 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 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.

Requires improvement

Are services safe?

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- 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 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 seclusions 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 distributed to staff summarising restrictive practices arising out of Winterbourne View and what should be considered. 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

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, the information was then 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 we spoke 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 telephone number, along with safeguarding information, was prominently displayed for staff to read. Staff we spoke with were aware of the policy and were 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 2014 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%.

Essex Site

Safe and clean ward environment

On Audley ward we found that a ligature point risk assessment had been completed with actions identified to manage the risks. However, when we spoke to staff about the identified risk due to the door handles within communal areas, and asked to see records for the hourly checks that were identified as an action, we were told that this was not available. We bought our concerns to the attention of senior staff within the unit and the hospital.

The seclusion suite on Audley ward had two-way communication facilities, a clock and toilet facilities. However, we observed a person having to be moved from Audley ward to Hadleigh ward to be secluded. When we spoke to staff they told us that in the bathroom of the seclusion suite on Audley ward they could not maintain clear observations due to a blind spot. We were told that the provider was taking action to address this issue as part of the refurbishment programme taking place during our inspection.

We were told that emergency resuscitation drills did not take place as part of ongoing staff training and noted that Hadleigh ward did not have resuscitation equipment despite having a seclusion and intensive care area. This equipment was available in the adjacent ward.

There was a pharmacy top-up service for ward stock. Other medicines were ordered on an individual basis. This meant that people had access to medicines when they needed them. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature as recommended by the manufacturer.

We saw controlled drugs were stored and managed appropriately. However, on Maldon ward one controlled drug was not being stored in line with the provider's policy as there was no controlled drug cupboard on this unit. This was bought to the attention of senior staff within the hospital.

Overall, the wards were clean, had good furnishings and were well-maintained. Ward cleaning schedules were in place with audits undertaken by senior staff. Staff told us there were systems for the "lock down" of the ward should an infection arise. Household cleaning products had been risk assessed as part of the control of substances hazardous to health (COSHH) and there were systems to ensure they were securely stored. Emergency equipment was available and checked regularly.

We noted an unpleasant smell across the site. We were informed that this was due to problems with the site's drainage system. One person showed us the ensuite

Requires improvement

Are services safe?

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shower in their bedroom and told us that water had been flowing back up the plug hole for some time and that this resulted in a foul smell. Senior management were aware of the problem and we noted that the maintenance team were trying to resolve the issue.

We noted some areas within the ward areas were excessively warm. We were informed that the provider was investigating the cause of this and received assurances that plans were in hand to address this issue.

Safe staffing

The hospital director said Dr Hurst's mental health / learning disabilities tool for identifying staffing levels was used to identify people's dependency needs and the level of staffing required. This Association of United Kingdom University Hospitals (AUKUH) acuity and dependency tool has been developed to help hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool, when allied to nurse sensitive indicators (NSIs), will also offer services a reliable method against which to deliver evidence-based workforce plans to support existing services or the development of new services. Nursing staff rotas were planned four weeks ahead. A doctor was on call 24 hours a day.

Daily hospital wide planning meetings reviewed staffing levels and needs and a red amber green (RAG) system was used to identify risk areas. Additional staff were requested using a centralised electronic system 'Trinity'. Most staff reported flexibility of staffing numbers to be able to respond to the need for enhanced observations.

On Easton Lodge, at times there was one member of staff due to being a small ward and people being assessed as more independent. Staff told us they could call for assistance from other staff on the site and site security if required, in an emergency.

On Danbury and Audley ward some staff said that despite staff rotas booking sufficient staff, they might be redeployed elsewhere in the hospital to support colleagues. This sometimes led to people having their Section 17 leave being cancelled, which two people confirmed with us.

Staff reported a high use of bureau (St Andrew's Healthcare staff) and agency staff. We saw some examples of difficulties in covering weekend and evening shifts. This could affect staff being able to take their breaks and provide leisure activities for people who used the service.

Some staff gave us examples of bureau and agency staff being used on wards that they were not familiar with. On some occasions, emergency response team staff said that they could not leave the ward to respond to emergency situations elsewhere in the service as they had to ensure a minimum of three staff stayed on the ward. We noted that in these situations additional support was given by security staff within the hospital.

Some people told us access to healthcare was poor as they had to wait to see a doctor but also said a GP visited weekly. Senior staff told us that 80% of people using the service smoked cigarettes. Smoking cessation support was available with nicotine supplements for those who wanted to stop. People's physical health needs were being appropriately monitored with regular checks completed for weight and blood pressure.

Assessing and managing risk to patients

We reviewed care records and we saw that most people's needs and risks were assessed and documented. The risk assessments detailed the actions that were required to minimise the risk to the individual, trigger behaviours and coping strategies. For example, staff assessed and supervised on wards people's access to sharp objects and other items that might present a risk to them or others. Most people who used the service told us that they felt safe. Gaps were noted in two records seen regarding the individual risk reviews carried out on each person. This was bought to the attention of unit based staff.

On Maldon ward we found that one person who had a serious enduring physical health need did not have a care plan or risk assessment in place to alert front line staff or provide guidance on how to help support and care for the person. When we spoke with staff they were not aware of any procedures that should be being followed or documentation that should be completed as a result of this physical health condition. The records seen did not demonstrate to us that this person was having their physical health needs met effectively by the service.

Staff had undertaken training in and where appropriate had used reinforce appropriate implode disruptive (RAID)

interventions when working with people who may challenge. We noted that staff used 'think back forms' with people as part of behaviour analysis after incidents and these were used to promote reflection on incidents and in clinical team decision making about changing risk status levels.

Staff received personal security in a secure environment (PSSE) training on induction and PMVA training was given after three months. There were alarm systems to summon assistance and security staff had PMVA training and also undertook restraint in addition to other disciplines.

Staff received mandatory training on safeguarding vulnerable adults and children. We found that 95% of staff at St Andrew's Healthcare Essex had undertaken level 2 training. Level 3 training was planned for the next two months and a session took place the week of our visit. Safeguarding reporting procedures had been reviewed since our visit in December 2013. There was a safeguarding log and systems to review this at management and ward/ team level. For example, 'safeguarding' was a standard agenda item at the monthly business continuity meeting with staff and people using the service.

Staff were given further information about safeguarding reporting procedures at staff forums in 2014 and they had received a leaflet, "safeguarding patients: recognising and responding to abuse - a guide for staff". Most staff we spoke with had a good understanding about safeguarding and knew how to report any issues.

Reporting incidents and learning when things go wrong

Most staff were aware of the systems to report and record incidents in the electronic patient' RiO' and 'Datix' system record. There were systems for reviewing these to consider actions to minimise any risks at local and provider level such as the hospital's daily handover meeting, patient safety and experience group and the quality and compliance groups.

A system for disseminating any learning points/actions identified had been developed where staff received 'patient safety alerts' by poster and email. This was now adopted across the organisation. A system was in place for reviewing and monitoring when staff had read them.

Alerts were further discussed at team/ward meetings to embed learning. Minutes we saw did not always detail the discussion around this. Most staff we spoke with could refer to this and gave examples of learning and changes made**.** For example, the provider changed the office doors to ensure that people could not reach in and grab items out of offices.

Staff reported that debriefs took place after incidents. A trauma counsellor was accessible to staff where required.

Are services effective?

Requires Improvement

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

Summary of findings

Assessment of needs and planning of care

- The views of patients in the Northampton men's service were not consistently included in care plans.
- In Northampton, generally patients had well written risk assessments and care plans. However on the two male specialised wards for patients with hearing difficulties and those with acquired brain injuries(Fairbairn and Rose), the care plans were very long and were not in a format which would assist patients to understand them.
- Health plans were in place.
- Care programme approach meetings took place.
- In Birmingham people's physical health needs were assessed and monitored to protect their health and wellbeing.

Best practice in treatment and care

- In Northampton, the medication records demonstrated adherence to professional guidance and we noted referrals had been made to specialist services where required.
- In Northampton, Spring Hill house the ward had established a treatment programme based on dialectical behaviour therapy (DBT).
- In Northampton, the provider had worked with the Royal College of Psychiatrists to adapt the Health of the Nation Outcome Scales specifically for service users in secure settings. These are reported to their commissioners in order to meet their contractual obligations.
- We received mixed feedback about the availability of activities at both locations however we saw systems were in place to monitor this.
- In Essex, we found that some staff had difficulty in accessing the electronic care and treatment records used throughout the hospital.
- Outcomes for people were also assessed through use of the health of the nation outcome scales (HoNOS) secure assessment tool. A range of therapeutic interventions in line with National Institute for Health and Care (NICE) took place.
- A Quality Network for Forensic Mental Health Services, peer and self-assessment inspection had taken place in St. Andrew's Essex Low Secure Wards in May 2014, with identified good practice and areas for improvement. We noted that the provider had already taken actions to address an area identified for improvement.
- In Nottingham, NICE guidance informed policies, medication practice and psychological interventions. One ward had introduced the concept of a theraputic community which was being embedded.
- In Nottingham, The hospital provided data for the first quarter that showed only one third of the activity offered to patients was taken up.

Skilled staff to deliver care

- In Northampton, we were told that there were issues around maintaining staff on Fairburn ward who were trained in British sign language (BSL). It often occurred that staff were trained up to a level to work with patients, then moved to work on other wards.
- In Northampton, staff received mandatory training annually which included safeguarding adults, basic life support training and training to ensure that restraint was applied safely when necessary.
- In Essex, staff confirmed that they had received mandatory training and this was confirmed by those records seen.
- In Essex, we found that staff had access to regular supervision and staff had received annual appraisals. We saw examples of additional training being provided for ward based staff
- In Birmingham, people were not consistently supported to participate in regular activities.

Multi-disciplinary and inter-agency team work

- In Essex, we found effective multi-disciplinary working (MDT) within the service to meet people's needs.
- In Nottingham, we found there were good multi displinary team meetings to review care which involved patients and analysed behaviours and incidents.
- In Nottingham, some patients had communication passports.

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- In Nottingham, there was an initative called "meaningful conversations" which had been introduced to facilatate dialogue by nurses which patients were postive about.

Adherence to the MHA and MCA Code of Practice

- Generally we found in Northampton that patients were regularly being assisted to understand the rights under the Mental Health Act. However, we found on Fairbairn and Rose wards this was not being consistently recorded. We also found evidence in patient notes of rights being documented as not understood and the next review date being six months ahead.
- In Essex, we saw clear procedures in place regarding the use and implementation of the Mental Health Act and the Mental Health Act code of practice.
- Advocates were available for people throughout the hospital and most people we spoke with told us they were aware of their rights.

Good Practice in applying the MCA

- Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). All staff we spoke with were able to tell us in detail how this related to the patients. In reviewing the care records, we found detailed capacity assessments relating to different aspects of the patients life and care provision. These were reviewed at the weekly team meetings.

Our findings

Northampton Site

Assessment of needs and planning of care

We looked at 47 sets of care records and found each patient had a full assessment of their care needs. Care plans and risk assessments were up to date, reviewed regularly at the team meetings and were recovery focused. These had been personalised for each patient to reflect their individual needs. There were specific care plans for physical health issues including care plans for physical health under restraint where this was indicated. Patients' physical health was assessed regularly and recorded so that any concerns could be monitored and action could be taken if required.

Generally patients had well written risk assessments and care plans. However on the two male specialised wards for patients with hearing difficulties and those with acquired brain injuries(Fairbairn and Rose), the care plans were very long and were not in a format which would assist patients to understand them

Best practice in treatment and care

The medication records demonstrated adherence to professional guidance and we noted referrals had been made to specialist services where required.

These services were able to offer psychological therapies as recommended by NICE and we found the women's service were proactive in engaging patients in treatment.

In Spring Hill house the ward had established a treatment programme based on dialectical behaviour therapy (DBT). We saw evidence which showed how members of the multi-disciplinary team had conducted and published research into this area. The care pathway for patients here also included access to range of non-secure accommodation as part of their care pathway.

The wards had an activity programme which was supplemented with individual activities for those unable to participate in groups. Staff and patients informed us that activities were often cancelled because staff were off the ward escorting patients, particularly in the men's service. We looked at the organisation's overall data around cancelled activities and found that, in August 2014, in the men's service over 123 hours of activities had been cancelled due to lack of staff as had 31.5 hours in the women's service. According to the organisations data, over 123.5 hours of 1 to 1 nursing interventions were cancelled in August for the same reason.

The provider had worked with the Royal College of Psychiatrists to adapt the health of the nation outcome scales specifically for service users in secure settings. These were reported to their commissioners in order to meet their contractual obligations.

Skilled staff to deliver care

Are services effective?

Requires Improvement

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

The ward teams included nursing staff, occupational therapists and a technical instructor, social workers, a consultant and a psychologist. The team on the ward worked effectively together.

Staff received mandatory training annually which included safeguarding adults, basic life support training and training to ensure that restraint was applied safely when necessary. Some nursing staff on the wards had received specialist life support training to meet the needs of one patient who had specific physical health care needs. This meant that there was always a member of staff who could provide specific care to this person were they to need it. Qualified nursing staff on the ward received regular monthly supervision and annual appraisals.

Serious concern was expressed to us about the movement of staff between wards. Fairbairn ward is a specialist ward for patients with hearing difficulties. Staff were trained in British Sign Language (BSL) to enable them to communicate effectively with patients. Senior management and medical staff expressed their concern around losing vital skills due to the practice of moving staff around. We were told that having invested time, finance and training into staff to ensure high quality care, they were moved away from the ward without explanation, being replaced by staff that had no training in BSL. Patients and staff confirmed this and said they believed quality of care suffered as a result.

People's physical healthcare was monitored regularly and we saw that levels of anti-psychotic medication were monitored to ensure that people's physical health care needs were met. There was a GP and specialist nurse practitioners who covered the Northampton site to whom people had access. People were offered access to smoking cessation support.

Multi-disciplinary and inter-agency team work

The ward team had weekly multidisciplinary meetings to ensure that information between the teams was shared. Staff across the disciplines attended regular ward rounds to discuss the needs of people on the ward.

Staff told us that they liaised with other teams when people were being admitted to the ward and discharged from the ward.

Adherence to the MHA and MCA Code of Practice

We looked at the Mental Health Act paperwork for patients and found it to be accurate and complete in all sections. This meant that patients were not illegally detained or treated. All consent to treatment paperwork was present and correct.

Generally we found that patients were regularly being assisted to understand the rights under the Mental Health Act. However, we found on Fairbairn and Rose wards this was not being consistently recorded. We also found evidence in patient notes of rights being documented as not understood and the next review date being six months ahead. Staff were unable to tell us or describe other methods they might use to assist that patient to gain an understanding of their rights.

Good Practice in applying the MCA

Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). All staff we spoke with were able to tell us in detail how this related to the patients. In reviewing the care records, we found detailed mental capacity assessments relating to different aspects of the patients' life and care provision. These were reviewed at the weekly team meetings.

Birmingham Site

Assessment of needs and planning of care

Records sampled included a care plan that was up to date and showed staff how to support the person to meet their needs. Care plans were focused on the recovery of the person who used the service. Two specific examples of treatment and support we looked at showed the people were making progress in respect of particularly challenging aspects of their care needs. Staff were clear and consistent in their responses to how these needs were being addressed. People's physical health needs were monitored. People who used the service told us that they had physical health checks. One person told us how they were supported by staff to attend regular appointments to manage their medical condition. Staff we spoke with showed a good awareness of individual physical health needs and how they were managed.

Best practice in treatment and care

We found that people received psychological therapies where needed to meet their needs.

Are services effective?

Requires Improvement

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

Offender treatment was offered to individuals where needed in Speedwell ward and not in groups. This meant there was treatment tailored to meet the needs of people who would benefit from one to one rather than group work.

People told us they had access to physical healthcare. We saw that, where needed, referrals were made to specialists to ensure that people's physical health needs were met.

Staff told us that an audit had been completed in the hospital that showed people who used the service were gaining weight following their admission to the hospital. In response to this the health professionals, including the dietician, had put in place a diet plan to ensure that people's physical health needs were not affected. People who used the service told us that they could understand some restrictions may be needed but felt this should be supported by regular access to physical exercise. They told us that they could not always go to the gym because staff were not available to escort them. Staff agreed with this but told us that gym equipment was being provided on the wards to help ensure that people had regular opportunities to exercise and promote their physical wellbeing.

Activities on the ward were provided and we saw some people playing pool and table tennis with staff. However, several people told us they were bored. One person told us that all they did was play cards. We observed that some people were sat around the ward not participating in any activity.

Staff and people who used the service told us that at weekends there were few activities provided. Staff told us this was because of the shortage of occupational therapists (OT) although these posts were being recruited to. People told us that some people could not leave the ward due to the risks to their safety and that of others. They said that this meant that limited activities were provided. We saw that a sensory room was provided on Edgbaston ward and staff told us that the OT did a project with people who used the service and they converted this room. However, people told us this room was not used often. One person told us, "there are excellent facilities in this hospital but we can't always access them due to staffing." on some wards there were not sufficient staff currently trained in gym use to be able to support people without a trained gym instructor being present. This meant some people were unable to use the gym as often as they wished. Staff told us there were plans to have gym equipment such as cycle machines available on wards.

Some people told us they had done some gardening, did their own laundry and sometimes cooked their own meals with support from staff, which helped to reduce their boredom. We saw that people in Northfield ward had access to external college courses and work placements. Some people worked on a local allotment which they said they enjoyed.

Skilled staff to deliver care

Staff told us that a qualified occupational therapist (OT) was not provided on Northfield and Edgbaston wards to ensure that regular therapeutic activities took place. A technical OT instructor was provided and they told us that the OT posts were being recruited to. They said that this would help improve people's opportunities to access regular activities particularly at weekends and in evenings.

Rotas showed and staff told us that there was always at least one qualified nurse on each shift. There were usually at least two qualified nurses on day shifts. Staff told us they received the training and supervision needed to ensure they had the knowledge and skills to meet people's needs. In Speedwell ward this included training for all staff in autism.

Multi-disciplinary and inter-agency team work

Staff told us and records showed that between each shift there was a handover. This meant that staff knew what support each person needed to meet their needs.

We observed on some wards meetings taking place between the multi-disciplinary team (MDT) of professionals that worked there, which reviewed the care and treatment that people who used the service received. We saw that the person was involved in the meeting about them and the MDT worked together well to ensure the person's needs were being met. Most staff told us they were involved in these meetings. However, some staff in Speedwell ward told us they rarely attended these even though they had worked on the ward for years. This could mean that the views of all staff that supported the person on a daily basis were not considered which could impact on how people's needs were met.

Staff told us they had developed good links with people's care co-ordinators. This meant that all agencies worked together to ensure people's care and treatment was effective.

Adherence to the MHA and the MHA Code of Practice

Are services effective?

Requires Improvement

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

We saw that people who were detained there under the MHA had the appropriate documentation in place for consenting to their treatment including medicines. Where people had been prescribed treatment without their consent, because they did not have the mental capacity to do so, or had refused to, we saw that a second opinion appointed doctor (SOAD) had seen them and stated that it was appropriate for treatment to be given.

Records we sampled showed that people's forms for when they had section 17 leave from the ward had been completed appropriately. These included a risk assessment completed before the person went on leave to ensure their safety and wellbeing.

Records we looked at showed that staff had attempted to explain to people their rights under the Mental Health Act (MHA). Six records we looked at showed that the person had refused this. However, staff had recorded that the person had understood their rights. This could mean that staff might not make further attempts to explain these to ensure that people were aware of their rights. One person's record in Speedwell ward clearly stated that the person did not understand these but no attempt had been made to inform the person in a way that was accessible to them. People had used their right to an appeal of their detention under the MHA. The checklist that staff used for informing people of their rights had two of these rights missing. These were the right to see the MHA code of practice and access to an independent mental health advocate (IMHA). This could mean that people were not aware of these and we found that few people who used the service accessed the IMHA.

Good practice in applying the MCA

All records we sampled included an advance statement that was completed with the person as to how they wanted to be treated.

Records showed that for all but two people in Speedwell ward, detailed assessments had been completed of each person's mental capacity to consent to their treatment. However, each person had an overweight/obesity plan to help them to lose weight and promote their physical health needs. Records did not show that the mental capacity of the person had been assessed to consent to this. Only two of the plans showed that the person had consented to this. We saw that a decision had been made for one person, who lacked the mental capacity to consent was in their best interests and in accordance with the MCA.

Nottingham Site

Assessment of needs and planning of care

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 plan 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

Are services effective?

Requires Improvement

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

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 include 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 healthcare nurse was on long term leave .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.

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

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 living and noncompliance. The survey identified 75% of the hospital population required anger and anxiety management, motivation to engage, social relationships

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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 is offered and so do not meet the 25 hours of activity target set by commissioners. Activities are 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 this is because when nurses review these and do not see it as important they can delete the entry. 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. 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 spreadsheet we saw gave reasons such as patients not attending, without specification of the reason for non attendance. There did not apprear 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

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.

Are services effective?

Requires Improvement

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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. However when weekend work occurred then sessions were 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

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 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

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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.

Essex Site

Assessment of needs and planning of care

Care plan headings and daily notes reflected the use of recovery tools such as 'my shared pathway' (MSP). Care records had clear plans and guidance for staff on how to support people who used the service to achieve their goals, whilst promoting independence. We saw evidence of people's diverse needs being met within care plans. For example information about people's cultural or spiritual needs. We saw that most care plans were developed with people's involvement. Some people told us that they kept a copy of their care plan in their bedrooms.

People had a physical health examination and an annual health check with additional assessment as required such as for smoking cessation. Information was available to staff about recognising the right of people to smoke and the need to monitor their health. Nicotine replacement therapy was prescribed when people were in seclusion/segregation and could not access tobacco. Systems were in place to communicate key information about people to acute hospital staff when required.

The provider had an assessment log to keep track of when assessments relating to people's care and treatment have been completed or were out of date. There were systems for this to be checked weekly by the ward manager and multi-disciplinary team.

Best practice in care and treatment

Staff offered therapy as recommended by national guidance, such as cognitive behavioural therapy (CBT). The head of programmes told us that six people were undertaking CBT, which was used where people had been in hospital a long time. Some staff were being trained in CBT. Staff gave an example of working with a person to overcome their phobia. Other therapies offered included 'stop and think' problem solving groups, mindfulness and advanced relapse prevention. A member of psychology staff was attached to each ward and 'drop in' sessions also took place on wards.

We saw good examples of effective outcomes achieved as a result of these therapies with individuals. For example, a reduction in incidents and self-injurious behaviours.

Outcomes for people were also assessed through use of nationally recognised assessment tools such as health of the nation outcome scales (HoNOS) secure, HCR20 - Historical Clinical Risk Management.

Staff encouraged people to use the recovery star self-assessment tool and the my shared pathway (MSP) booklets. MSP is part of the national secure services QIPP programme. It is developing a recovery approach to identifying and achieving outcomes and aims to streamline the present pathway for service users in secure services. People identified their needs with staff and outcomes they want to achieve with timelines. This influenced their care plans.

OT staff reported using assessment tools to measure people's progress such as the occupational self-assessment (OSA) and the model of human occupation screening tool (MOHOST).

There were systems to provide a minimum of 25 hours of therapeutic activity in the week. Activities such as 'breakfast club', sport activities and social skills were offered. Information was available to ward staff about the number of therapeutic hours provided to people. For example on Danbury Ward, from 04 to 10 August 2014, 20% of activities were recorded by staff as attended; 20% not

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and 60% were waiting to be 'outcomed' as staff had not yet recorded people's attendance. This lack of effective recording was bought to the attention of senior staff during the inspection.

During a morning visit, we observed several people asleep in chairs. We saw that some activities were taking place off the ward. Senior staff told us that they would take action to ensure more encouragement was given to people to attend activities.

On Easton Lodge, staff reported undertaking individualised activities with people such as money management.

Skilled staff to deliver care

Each ward had an identified multi-disciplinary team including doctors (Including consultant psychiatrists), nursing, occupational therapy (OT), and psychology and social work staff. Additionally there was access to specialist staff such as a dietician, physical fitness instructor and chaplain.

Staff confirmed that they had received mandatory training and this was confirmed by those records seen. We found that staff had access to regular supervision and had received annual appraisals.

The records seen showed us that the provider was recruiting staff on an ongoing basis and that induction training was provided each month for new staff. However, we noted difficulties with staff retention once people had completed their induction programme. This was confirmed by those staff retention figures reviewed.

Multi-disciplinary and inter-agency working

Each ward had shift handovers. Staff reported that if they had been off duty from the ward for more than three consecutive days the nominated safety nurse gave them a full handover and a health and safety checklist was completed to ensure that staff were aware of people's current care and risk behaviours.

New nursing handover sheets related to the relational security explorer, from the 'see, think, act' Department of Health handbook. Some staff reported it was not an improvement to the previous one and we saw it was difficult to read some handwriting. A daily planning meeting was attended by staff across all wards/department to report key issues for the ward/unit such as staffing, incidents, leave, safeguarding and admissions.

We spoke with agency staff who told us that they did not have access to the RIO system. They solely relied on the paper handover sheets. This meant that they did not have full access to people's medical notes and were not always aware of any recent risk behaviours or changes in care plans.

The unit had an identified police liaison officer and staff reported an effective working relationship. Staff reported in relation that police investigations could be lengthy and at times they did not receive feedback as to the outcomes of these.

Systems were in place for staff to regularly meet with the local commissioners that funded people's care. Specialist commissioners from NHS England met with senior managers as required.

Adherence to the MHA and the MHA Code of Practice

91% of hospital based staff had undertaken MHA training.

The units had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act code of practice. Advocates were available to people on the ward and most people we spoke with told us they were aware of their rights.

We found that the statutory systems were in place for planned and emergency admissions and the records seen showed us that people had been informed of their rights of appeal against their detention. We found systems in place for staff to produce statutory reports where people had appealed against their detention to first tier tribunals and hospital managers' hearings.

We reviewed the information provision available to the informal patient regarding their rights to leave the ward and saw that satisfactory arrangements were in place

Good practice in applying the MCA

91% of staff were trained in the Mental Capacity Act 2005 training including training relating to Deprivation of Liberty Safeguards (DoLS).

We saw that the provider had systems in place to assess and record people's mental capacity to make decisions and develop care plans for any needs. Most staff demonstrated awareness of the Act.

Good

Are services caring?

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

Summary of findings

Kindness, dignity, respect and support

- In Northampton, regular staff were able to articulate individual patient's preferences and daily needs.
- In Essex, most people told us that staff were approachable and they gave them appropriate care and support.
- In Essex, we found that people who used the service were treated with dignity and respect.
- In Essex, staff were caring and compassionate, and they were motivated to make sure that people were well supported
- In Birmingham, all visits to people were supervised by staff which impacted on people's privacy.
- In Nottingham, there was a mixed picture of the way that patients were treated by staff. We observed some staff to be caring and compassionate. We also observed staff swearing in the office and heard that there had been problems with staff at Rufford ward in particular.
- In Nottingham, not all patients felt their religious and spiritual needs were respected.

The involvement of people in the care they receive

- In Northampton, we saw from patients' records the provider used the 'my shared pathway' (MSP) approach, which is a recovery and outcomes based approach to the planning and delivery of care.
- On Spencer North ward in Northampton, we were invited to attend two care programme approach meetings. Both of these were chaired by the respective patients. During the meeting the patients' electronic record were displayed and any decisions were clearly explained to the patient.
- We found that the men's service were not consistently documenting patients' views in the records whether attempts had been made to engage people in the process.
- On Rose ward in Northampton patients received an information pack about the ward which included pictures to assist them to understand the content. We saw how this pack was personalised for each person and included information about care reviews, how to complain, the ward activities and names and pictures of their care
- In Essex, the provider had systems to encourage people to be involved in their assessment, care planning and reviews through use of recovery tools such as 'my shared pathway'. People had the opportunity to attend a hospital based 'service user forum'.
- In Birmingham, most people were involved in their care and treatment plans. However, some people in Speedwell were not always involved in this care as information was not provided in a format they could understand.
- In Nottingham, out of area placements posed difficulties for friends and families visiting and participating in specific meetings.
- In Nottingham, there was an active patient representative group "our voice" who had formulated and action plan for changes they required. Representatives from the group had participated in training and interviewing.
- In Nottingham, advocacy was available and used although requests for it were not often made in relation to safeguarding issues.

Our findings

Northampton site

Kindness, dignity, respect and support

We observed the engagement between patients and staff on all wards. Staff appeared to interact in a respectful and caring manner. We noted staff knocking on bedroom doors before entering.

However on the male wards, at times the interactions appeared at times to be more functional and reactive to behaviour rather than spontaneous. Six patients told us this was the case and felt that the cause on occasions was the lack of awareness by agency and bureau staff of patients' communication and engagement needs. Regular staff were able to articulate individual patients' preferences and daily needs.

The involvement of people in the care they receive

We saw from patients' records that the provider used the my shared pathway (MSP) approach, which is a recovery and outcomes based approach to the planning and delivery of care. We found differing practice between

Good

Are services caring?

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services. The women's service records showed that people were involved in their care plans and that their views had been included. Patients we spoke with told us they had been asked about their views and had been involved in planning their care.

On Spencer North ward we were invited to attend two care programme approach meetings. Both of these were chaired by the patients. During the meeting the patients' electronic records were displayed and any decisions were clearly explained to the patient.

The men's service was not consistently documenting patient's views in the records or whether attempts had been made to engage people in the process.

Both services were able to evidence involvement of relatives in care review and planning. One relative expressed concern that the efficiency of the care planning process and discharge planning had reduced since the process had become centralised in the organisation. They told us "the organisation was doing good work but the actions don't always happen and communication had slowed down."

There was a regular community meeting held on the wards weekly where people were able to input their views and ideas into the running of the service. The service received input from advocacy services. On Rose ward, patients received an information pack about the ward which included pictures to assist them to understand the content. We saw how this pack was personalised for each person and included information about care reviews, how to complain, the ward activities and names and pictures of their care team.

Birmingham site

Kindness, dignity, respect and support

We observed respectful and positive interactions between staff and people who used the service. One person said, "the staff are good here, it's a nice atmosphere and I feel like a weight has been lifted off my shoulders in here."

All people spoken with told us that staff were caring and that they listened to people. One person who used the service told us, "it's the best hospital I've ever been in."

Another person said, "staff offer a high standard of care." one person told us staff were "superb". Another person said that they thought staff were much more approachable at events such as summer fetes than they were on duty.

Staff demonstrated that they had an understanding of the individual, cultural and religious needs of people who used the service. There was a diverse mix of staff that reflected the diverse mix of people who used the service.

The involvement of people in the care they receive

People who used the service showed us round their ward. They told us that they often showed new people admitted to the ward around to help them to know about the ward and find where everything is.

People told us that they were involved in their care plans and had a copy of these. One person said, "staff sit with me and review my care plan with me, then I sign it." We saw in records we sampled that people were involved in most of their care plans and had signed to agree to these. In Speedwell ward we found that care plans were not in a format that was accessible to people who used the service. This did not enable people to be involved in their care plan and staff told us that most people were not involved in these.

People told us that the community meetings held on the ward were helpful and staff listened to them. People who used the service and staff told us that people were involved in interviewing new staff. In Edgbaston ward staff and people who used the service told us that people were involved in developing the ward 'rules'. Staff told us that this helped people to 'own' these and follow them more often. They also said that the 'rules' applied to staff not just people who used the service and this was important in respecting people.

Staff, people who used the service and their relatives told us that all visits were supervised by staff. Some people and their relatives told us they did not understand the reasons for this. We discussed this with the hospital director who agreed to ensure that visits would be risk assessed for individuals to ensure that people's privacy was not compromised unnecessarily.

We spoke with a small group of families and carers. They told us there was a carers group set up that met regularly, although attendance was difficult for some relatives who lived a distance away. One person had travelled a hundred

Are services caring?

Good

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

miles to be present. They felt information and communication was a problem. They told us they felt there was very little information for relatives and carers when a person was first admitted to St Andrew's. People who used the service told us that they sometimes had difficulty accessing the independent mental health advocate (IMHA). There was one IMHA who provided a service to all people at the hospital to ensure their views were listened to. Some people told us that this meant that they could not always obtain advice from an IMHA. One person's records we sampled had frequent contact and support from the advocate. Some people told us they had little contact with the advocate, as she was busy with other people.

People who used the service spoke positively about the care they received from staff. One person said, "coming here has been the making of me."

Nottingham site

Kindness, dignity and respect

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 staff 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 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

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.

Good

Are services caring?

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

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 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.

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 money on their phone card 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.

Essex site

Kindness, dignity, respect and support

People told us that staff were kind and caring. The hospital director told us there was an identified staff dignity champion for the hospital. This person provided leadership and guidance to front line staff about the importance of maintaining the dignity of others at all times.

When we observed meetings, we found that people were informed of meeting times and the MDT gave explanation for involving people. We observed and heard staff communicating in a way that enabled people to understand and contribute meaningfully to the process.

Staff were familiar with the needs of the person being discussed. We found that people were involved in decisions about their risks assessments and management plans. We saw that staff were planning a community discussion about treating others with dignity and respect.

The involvement of people in the care they receive

We found evidence where people's strengths and views were identified in their care plans. For example their interests and things they wanted to achieve. We saw that care plans reflected the individual's person's needs and choices as far as possible.

We found that some paper care plans in files were not signed. They were in very small print and it was not clear if an easy read/large print format was available

We received mixed views from people about their involvement in their care planning. For example, on Audley ward two people told us they were not involved in their care planning and did not receive copies of their care plans. However, on Maldon ward people told us that they felt involved in their treatment and supported in making decisions about their care and had a copy of their care plan which they kept securely in their bedrooms.

Good

Are services caring?

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

We observed that staff spoke about people who used the services with respect. Staff spoke about people using the service in a positive and caring way and were motivated to ensure that people who used the services were safely cared for.

On Danbury ward we observed staff conversations about how they planned to involve and engage people in decisions about their treatment and sourcing internet information to give to people to help them understand their mental health.

Where we observed ward meetings we saw active involvement and participation from both staff and people who used the service. People were encouraged to chair their own meetings and supported in minute taking. Most people told us that they had regular contact with their families and friends. Solicitors and independent advocates were available for people.

Ward notice boards displayed information for people about treatment choices and included opportunities for them to meet and to discuss their medication with the hospital's pharmacist.

Good

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

Access, discharge and bed management

- In Northampton, we saw that all patients had a discharge plan except those on Cranford and Robinson wards. However, there were sometimes delays in discharges when people moved back to their home areas due to the availability of appropriate facilities.
- In Northampton on Hereward Wake and Spring Hill house both patients and staff we spoke with told us they were concerned about the impact on care pathways as a result of changes to commissioning arrangements. This would mean when patients were ready for discharge they may not be able to access the local step down facilities as these would no longer be funded.
- In Nottingham, we reviewed case notes and found that discharge planning was included in care plans involving the person and family and agencies.
- In Birmingham, staff worked with community teams to plan people's discharge from hospital

The ward environment optimises recovery, comfort and dignity

- In Northampton, 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.
- Patients on Grafton ward had moved from a ward where they had had ensuite facilities and outdoor space to a ward that did not have these.
- In Birmingham wards were generally comfortable. However some improvements could be made.

Ward policies and procedures minimise restrictions

- In Northampton, blanket restrictions were in evidence on each ward we visited such as no patient internet access and doors being locked during the day. There were practices on some wards designed to facilitate patients attending groups such as bedroom doors being locked during activity sessions.
- In Nottingham, we observed that patients were able to personalise their bedrooms, on Thorsby ward they had also decorated the de-escalation room.
- In Birmingham all people were searched on return from leave regardless of their assessed risks.

Meeting the needs of all people who use the service

- In Birmingham, we found the service met people's religious and gender-specific needs.
- In Birmingham, staff had access to good interpreting services. This meant that people could communicate their needs effectively, and staff knew how to respond.
- In Essex, we saw evidence in people's care and treatment records of how the service had reviewed and amended treatments in order to meet their changing assessed needs. We reviewed some good examples of responsive care during the inspection.
- A Quality Network for Forensic Mental Health Services, peer and self-assessment inspection had taken place in St. Andrew's Essex Low Secure Wards in May 2014, with identified good practice and areas for improvement. We noted that the provider had already taken actions to address an area identified for improvement.
- People's physical health needs were being appropriately monitored with regular checks completed.
- Chaplaincy information was displayed on wards.
- In Essex there was evidence of site developments to respond to people's assessed needs. However there were not consistent systems for staff to respond to and meet people's diverse cultural and language needs on Frinton ward.

Listening to and learning from concerns and complaints

- In Northampton, several patients told us they waited to speak to regular staff as they questioned the knowledge of the bureau staff.
- In Northampton, each ward had a book dedicated to learning from incidents and complaints generated across the hospital site. This ensured learning not just from their own ward but from other services. We saw action plans arising from complaints and the resultant changes on the wards.

Good

Are services responsive to people's needs?

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

- 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.
- Patients told us they were not satisfied with the complaint process. They feel their complaints were rarely fully addressed and often do not receive a clear response.
- In Birmingham, we found that concerns or complaints were dealt with and improvements made where needed.
- In Essex, information about how to make a complaint was clearly displayed on the ward noticeboards for people to read. People told us that they felt well supported by staff in making complaints.
- In Essex, complaints and concerns raised were discussed at the monthly 'patient safety and experience group' meeting to ensure that actions were completed and responses and feedback sent to people in a timely manner.

Our findings

Northampton Site

Access, discharge and bed management

We saw that all patients had a discharge plan except those on Cranford and Robinson wards. We were told there were sometimes delays in discharges when people moved back to their home areas due to the availability of appropriate facilities. There were social workers based on the wards to assist with discharge pathways from the hospital.

On Hereward Wake and Spring Hill house both patients and staff we spoke with told us they were concerned about the impact on care pathways as a result of changes to commissioning arrangements. This would mean when patients were ready for discharge they may not be able to access the local step down facilities as these would no longer be funded.

The ward environment optimises recovery, comfort and dignity

The wards had a range of rooms for providing support and treatment. There were quiet rooms for patients who wanted privacy to make phone calls or receive visitors. There were different areas where people could sit if they wanted to be with other people or to be on their own.

Patients across the service told us they felt the environments all over the site could be cleaner and the furniture in some places was damaged and not replaced. Female patients pointed this had a negative effect on their experiences.

Many 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.

Patients on Grafton ward had moved from a ward where they had had ensuite facilities and outdoor space to ward were they did not have this. One person told us they were not happy to share the bathrooms. People told us they had not been involved in the discussions regarding the move.

Ward policies and procedures minimise restrictions

Blanket restrictions were in evidence on each ward we visited. These included no patient internet access and bedroom doors being locked during the day There were practices on some wards designed to facilitate patients attending groups such as bedroom doors being locked during activity sessions. If patients requested access to their room during this time, it was not denied them. All care was personalised and any restrictions for individuals were risk assessed, documented and reviewed regularly.

All patients were subject to the Mental Health Act. However we noted signs informing us that any informal patients were able to leave the ward when they wished.

Patients' bedrooms had been personalised with their own belongings and photographs.

Some patients on Grafton ward told us they had limited cigarettes breaks during the day because the ward did not have access to outside space.

Patients had access to a telephone which ensured that private telephone calls could take place.

Meeting the needs of all people who use the service

Good

Are services responsive to people's needs?

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

Most patients we spoke with told us that they felt their needs were met by the services provided on the ward. We saw that people had access to advocacy and chaplaincy services which covered major religions. An interpreter service (including sign language) was available to patients.

On Foster ward there were two Polish patients and we saw the arrangements in place to provide translation services for them at formal meetings and on a daily basis. This was through accessing the provider's translators or utilising Polish speaking staff.

Listening to and learning from concerns and complaints

Information about services on the wards included information about complaints and access to advocates.

Patients we spoke with told us they spoke to the staff if they were unhappy about anything. Several patients told us they waited to speak to regular staff as they questioned the knowledge of the bureau staff.

Fairbairn ward demonstrated learning and change of environment as a result of patient concern. Patients' raised concern for privacy as they were unable to hear staff knocking on their bedroom door. The ward installed a flashing light system into patient's bedrooms to alert them when a member of staff was waiting to enter.

Each ward had a book dedicated to learning from incidents and complaints generated across the hospital site. This ensured learning not just from their own ward but from other services. We saw action plans arising from complaints and the resultant changes on the wards.

Birmingham site

Access, discharge and bed management

We found that people were not moved around the wards unless it was in their interests and part of their care pathway. For example, some people told us that they had moved from the medium secure wards to the low secure wards as they had progressed in their treatment.

We were told that beds were not used when a person was away on leave and saw no evidence to contradict this. People were only moved for one ward to another for valid clinical reasons. We were made aware of situations where people had used a seclusion room on a ward other than their own on a few occasions.

We saw that discharge of a person from the ward was discussed in MDT meetings. This was not delayed unless there was a reason why it was not in the person's interests to be discharged.

For example, we found one person's discharge from the hospital had been delayed. We spoke with staff and looked at the person's records. We saw this was because the identified accommodation for the person to move to was not appropriate to meet their needs. Therefore, it was not in the person's interest to move there. Further accommodation was being sought to ensure their discharge would be suitable.

The ward environment optimises recovery, comfort and dignity

Northfield ward was refurbished in July 2014. We observed and people who used the service told us that the ward was comfortable and there were different areas where people could relax.

There were adequate rooms where activities and therapies could be provided in Hawkesley ward. There was a gym adjacent to the ward so that people who did not have leave out of the ward area could access this.

We saw that Speedwell ward was very big and provided a service for up to 18 people. Staff and people who used the service told us that this was too many people and did not help to meet people's specific needs.

In Edgbaston ward we saw that a range of rooms were provided where people could do different activities. However, people told us that access to these was often limited as staff were not available to support them when using them. Some people told us that the lights were too bright, which meant that in the evenings it was not a relaxing environment. We saw that the walls were painted in the same colour and there were few pictures to make the environment relaxing. One person told us, "it's clinical, not comfortable." We saw that stools were provided in the dining room. People told us that these were uncomfortable. One person told us that they had requested that small tables be provided around the ward to put drinks on. They recognised that this could be a risk and the tables may need to be secured to the floor but they did not think that this needed to be an obstacle in providing them.

We saw that people could make a phone call in private and people said they used the phone when they wanted to.

Good

Are services responsive to people's needs?

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

On all wards there were set times where people were supported by staff to go outside the ward. People told us that the hospital plan was to reduce this to six times a day so these breaks did not affect therapeutic activities. One person said this did not bother them. However, some people expressed concern that this did not give them enough time to go out of the ward if they had no other leave granted.

All wards were single sex and all bedrooms had an ensuite shower and toilet.

Some people told us that they disliked the food and the choice was limited. They told us that there was a menu which changed according to the seasons but this was repetitive. However, some people told us that the food was good and they thought the menu was varied. Some people told us that the food portions had been reduced to try to support people to lose weight and promote their physical health. Staff told us that this had resulted in confusion for some staff and they had not known whether or not to give further portions if people wanted them. However, they told us that further portions of fruit and vegetables were always available and all staff had now been informed of this.

People told us that they could make drinks when they wanted them and had access to snacks.

Ward policies and procedures minimise restrictions

In Northfield ward people who used the service told us that they did not have the keys to their bedroom or the lockable space in their bedroom. They said that they had to ask staff for the key each time they wanted their bedroom unlocked. One person said, "it's a bit embarrassing, you have to ask someone to go into your bedroom. This is supposed to be a step down ward as well." The hospital operated a risk policy and people moved between the different levels depending on the risks to their safety and wellbeing. The policy stated that if a person was on this ward that they would be able to have a key to their bedroom. Staff told us that keys had not been available since the ward was refurbished and thought this was an unacceptable delay. The hospital director explained that there had been a problem with the key supplier but told us this would be done to ensure that people's independence was promoted.

Each ward had a small kitchenette so that people who used the service could make hot drinks. We saw this was locked on Hurst ward. A staff member told us this was because at least one person who used the service was at risk from having too much sugar. We queried why the kitchen could not be left open and just the sugar locked away, so people could make hot drinks at any time and only had to ask for sugar. We saw that staff responded promptly to requests to use the kitchenette.

In all wards we saw that people could only go outside the ward into the garden when supervised by staff. Staff we spoke with were unsure why access to the garden was restricted for some people. It was not clear in people's records we looked at why some people had regular unescorted access in the community but could not go out in the garden when they wanted to.

All people who used the service were searched when they returned from leave. Staff told us this was for safety and security reasons and gave us examples of contraband items being smuggled into the unit various ways. We queried whether a regime of random searches may be more effective. None of the people who used the service that we spoke with complained of the search procedure. Managers and staff told us that many restrictions, such as on the 'trading' of items, were in place to protect more vulnerable people from being exploited by others.

We saw that people were able to personalise their bedrooms.

Meeting the needs of all people who use the service

Staff and people who used the service told us that interpreters were provided if needed to help people understand their care and treatment. They told us that these were always available. There were staff who spoke a variety of languages other than English.

Staff and people who used the service told us that there was a choice of food that met people's religious and cultural dietary needs.

Listening to and learning from concerns and complaints

People told us they knew how to complain. They said that these complaints would be listened to and action taken to make improvements where needed.

Nottingham site

Access, discharge and bed management

Good

Are services responsive to people's needs?

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

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

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

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

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

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.

Patients told us they were not satisfied with the complaints process. They felt that their complaints were rarely fully

Good

Are services responsive to people's needs?

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

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. Patients 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.

Essex site

Access, discharge, and bed management

The hospital director told us that length of stay varied for wards. For example, the average for Maldon was 13 months and Danbury 9 months. As of 09 September 2014, there were 10% of people with a delayed discharge, waiting for beds elsewhere. This was supported by those records reviewed.

People were sometimese moved to alternative wards that were not always best suited to their needs. We spoke to senior staff about this and were informed that careful consideration was given by the multi-disciplinary team when deciding if someone needed to be transferred to another ward and their best interests were considered.

The provider was responsive to people and commissioner's needs. A project had been undertaken to investigate whether a neuropsychiatry service was needed and more recently managers had been assessing if there was a need to develop a male PICU.

On Danbury ward there was a mix of people with contrasting needs as some people required long term care. Some people had been in the hospital for over five years. One person told us, "Very few people get discharged and people give up." We found that some people were newly transferred from prison and they presented as more acutely unwell than the other people on that ward.

There were identified care pathways for people admitted to Danbury or Hadleigh wards then they would move to Easton Lodge as part of their transition out of secure services. Staff told us that they carefully assessed people for the move to the open rehabilitation unit, this ensured the appropriate mix of people as it was a small house. There could be times when there were vacancies. Delays sometimes occurred for people due to issues with funding approval.

There were opportunities for people to learn or maintain their skills and independence to the level they felt they were able to manage. For example, people could carry out laundry, cooking, money management and travel by public transport. If people were unable to do any activities of daily living staff supported them. At Easton Lodge this was evident as the environment was more domestic and less like a hospital. Staff supported people as required with shopping and budgeting.

On Hadleigh ward staff told us that there was a waiting list for admission and the ward was full during our visit. The hospital director told us that staff tried to assess people within 48-72 hours of referral.

A staff member told us that at times unsuitable referrals were made and people were admitted with complex needs from prison. We learnt that a serious incident took place where the police had to be called to assist staff to manage a situation. A serious investigation (SI) took place to identify learning points and lessons and we received assurances that the findings would be discussed at the patient safety and experience group.

The ward environment optimises recovery, comfort and dignity

Clinic rooms were available on all the wards apart from Maldon Ward. Medicines and clinical equipment was stored in the ward office on this ward and people had to receive their medication or any treatment they required there. On the day of the inspection we observed this and found that people's dignity was compromised as they were constantly interrupted with staff coming and going from the office, other people knocking on the office door requiring assistance and the telephone ringing.

People could be seen through the large office window receiving their medications. People told us that they did not like being observed and that it made them feel uncomfortable. Staff told us that they had suggested to management that an unused room on the ward could be converted into a clinic room but as yet this had not been agreed.

Good

Are services responsive to people's needs?

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

There were identified areas for people to have visits with family, friends or professionals for privacy. There was a designated visitor's room outside the secure perimeter in reception. Staff told us that refurbishment plans were in hand to provide a specific child friendly room.

Each ward had a private room where people could make telephone calls. On Easton Lodge people had access to mobile phones and told us they had regular contact with family/friends.

Staff told us planning permission was being sought to build a football pitch outside the secure area for people and staff. There was a garden allotment where people and staff could grow fresh produce. However when we visited, people were not interested in using this. Groups promoting healthy eating took place. People had access to the onsite gym and could meet with the fitness instructor to discuss their needs. A number of people told us how much they enjoyed the gym facilities.

A patient information folder gave information relating to recovery such as local resources. Each person received a copy of their weekly activity planner which contained information such as their scheduled therapeutic activities, leave from the hospital grounds and ward meetings. Information on advocacy, the complaints process and Mental Health Act (MHA) rights was available to read on the ward noticeboards.

People told us that they could access cold drinks when required but that hot drinks were only available hourly. Some people told us that they were not happy to have to wait for a hot drink at night.

Each ward had direct access to a garden. These were well maintained and provided seating as well as a smoking shelter for people to use.

Ward policies and procedures minimise restrictions

We saw that people could personalise their bedrooms. For example, people had posters on their walls and photographs in their rooms.

On Easton Lodge people who were not detained under the Mental Health Act had signed agreements/contracts stating they would abide by the rules of the hospital. These included not bringing or consuming drugs/alcohol on site, telling staff where they were going on leave and returning by a specified time. We saw the people had access to significant periods of leave as part of managing their transition from hospital to community.

Meeting the needs of all people who use the service

Chaplaincy information was displayed on wards. We saw systems for staff to undertake spiritual assessments with people, for example at Easton Lodge.

The provider had timetables to offer people a weekly minimum of 25 hours therapeutic activity and for tracking attendance. The lead OT told us that people had an individualised activity timetable for the week. This had 'essential' activities to attend and for most wards there was a payment incentive scheme. The lead OT told us that people were given a copy of the range of activities available and then chose what they wanted to attend. This was then negotiated with the MDT and agreement gained for their activities timetable. Activities were provided by the multi-disciplinary team, in addition to therapy sessions, some were leisure or community based. There was a mixture of closed and 'open' groups where people could attend when there was vacancy or had leave granted.

Some activities focused on the social inclusion of people such as adult education and vocational services for example "dog walking". People were supported as appropriate to get passes to use local amenities such the buses, library or gym. Library and computer facilities were available onsite and there was a visiting mobile library.

If a person required assessment from an OT for physical health issues, for example if they had mobility difficulties, this was requested from the central Northampton site and if any equipment was required then the person's local commissioners would be contacted for funding. Staff told us that this process often caused delays in accessing the required equipment that was needed to support people in their daily living. For example, on one ward we saw that a person had been without their mobility aid for over a week due to a fault with the equipment. This was bought to the attention of senior staff on the unit concerned.

Some people told us the food was good. Food was prepared on site and people could choose from a menu. The provider had systems to assess and monitor the quality

Good

Are services responsive to people's needs?

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

of the service and gain feedback. Access to the ward kitchen was restricted due the risks people could pose to themselves or others. There were identified meal/hot drink times.

Listening to and learning from concerns and complaints

During our visit, three people raised concerns with the inspection team about issues (not solely related to the provider and this core service) and we passed these on to senior staff who confirmed that these would be investigated in line with their complaints procedures.

Information about how to make a complaint was clearly displayed on the ward noticeboards for people to read. People told us that they felt well supported by staff in making complaints.

Complaints and concerns raised were discussed at the monthly 'patient safety and experience group' to ensure that actions were completed and responses and feedback sent to people in a timely manner.

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

Vision and values

- In Northampton, most staff were aware of the senior management within the provider. However, some staff told us that they felt there was a disconnect between the executive team and the teams on the wards.
- In Nottingham, patients who used services did not consider that ward leaders were visible.
- The staff were aware of the providers' board members, but were not clear about the providers' strategic direction.
- In Essex, we found that the provider provided information to staff and people about their service in different and effective ways. Most staff were aware of the provider's core values.
- In Nottingham, patients' told us they did not consider that ward leaders were visible.
- In Nottingham, the staff were aware of the provider's board members, but were not clear about the provider's strategic direction.
- In Essex the provider provided information to staff and people about their service in different and effective ways.
- Most staff were aware of the provider's core values.

Good governance

- In Northampton, the service had regular ward manager meetings weekly. Information in these meetings was collated and fed into meetings at ward level.
- In Northampton, there was a divisional quality and compliance meeting which met to feedback and ensure learning across the service and this fed into the quality and compliance meeting across the provider.
- In Northampton, there were separate 'lessons learnt' meetings following incidents and the information from these meetings was fed back at ward level. These meetings ensured that quality at ward level was monitored. The ward managers had a good understanding of the risks on the wards and within the service which meant that information was shared and promoted learning.
- In Nottingham, supervision was provided however was not consistent. We observed a reflective practice session which was led by a psychologist this had been implemented to make improvements.
- In Nottingham, appraisals were provided annually for all staff with a high level of compliance.
- In Nottingham, mandatory training compliance was monitored monthly and 91% was achieved for June 2014.
- In Birmingham the hospital's medicine management policies were not followed by pharmacy staff.
- In Birmingham, people's personal information was not always kept confidential and handled correctly.
- The provider had a governance framework in place in Essex with links for feedback to/from the central site at Northampton. For example we noted that 'out of hours' visits by senior staff and unannounced visits from directors took place with reports on the quality and experience of care provided.

Leadership, morale and staff engagement

- In Northampton, wards in the forensic services spoke highly of the multi-disciplinary team.
- In Northampton, some staff in forensic services were concerned about the long term impact of the organisation's project to upgrade wards to meet the standards required.
- In Birmingham, staff were generally well supported by their managers and by the senior management. Staff in Speedwell ward were not supported to take their breaks. There were insufficient occupational therapy staff which led to some staff feeling unsupported.
- In Essex most staff reported support from their manager. They told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. Most staff reported managers were approachable and they were effective leaders.
- We noted that there were no unit managers in place for Danbury and Frinton wards at the Essex location.

Commitment to quality improvement and innovation

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.

- In Northampton, most staff had a good understanding of the performance of the ward within the provider. However, the ward management teams had strong plans focusing on improvement.
- In Birmingham, people who used the service were listened to and, as a result, improvements made.
- In Essex, people and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys.

Our findings

Northampton site

Vision and values

Most staff were aware of the senior management within the provider. However, some staff told us that they felt there was a disconnect between the executive team and the teams on the wards. One person told us they felt there had been an improvement with the new chief executive who had been recently appointed.

Some ward staff expressed concern around the bureau staff's knowledge and perceived involvement in the provider's vision. A member of staff told us "bureau staff don't seem to have a sense of involvement in the organisation, most just come do a job and go away again"

Good governance

The service had ward manager meetings weekly. Information in these meetings was collated and fed into meetings at ward level. A divisional quality and compliance meeting met to feedback and ensure learning across the service and this fed into the quality and compliance meetings across the provider. Action plans were sent back to the ward, however there appeared to be technical issues around accessing these on the electronic system. This meant that ward managers could not always access the plans to make the identified changes on the wards.

There were separate 'lessons learnt' meetings following incidents and the information from these meetings was fed back to a ward level. These meetings ensured that quality at the ward level was monitored. The ward managers had a good understanding of the risks on the wards and within the service which meant that information was shared and promoted learning.

Leadership, morale and staff engagement

Staff on the wards told us they felt supported by their direct line managers and there was good teamwork and morale on the ward. All ward staff we spoke with spoke highly of the multi-disciplinary teams.

Some staff we spoke with felt they had not been briefed particularly well by the provider about the rationale for the moves and felt this had a negative impact on their morale. We spoke with ward managers and they confirmed they had participated in the planning and decision making process, and told us they had tried to share this information with both patients and staff.

On each ward we visited involved in the services that did not meet NHS England environment standards, staff told us the local leadership was good and they felt there was good team working. However, they were concerned about the longer term impact on team working following the environmental improvement project. Some staff told us they had not been involved in this change process and felt disconnected from it. One member of staff told us that the organisation's senior management were "in a slightly different world".

Commitment to quality improvement and innovation

Information was available at a ward level regarding the quality metrics. Most staff had a good understanding of the performance of the ward within the provider. However, the ward management teams had strong plans focusing on improvement.

Birmingham site

Vision and values

Staff and people who used the service told us that the executive team of the provider had visited and listened to their views. Staff told us that the chief executive contacted them through email weekly and there was an opportunity for staff to respond to this. Staff told us that the hospital director visited the wards regularly and spoke to staff and people who used the service. There were also opportunities to meet with the hospital director if staff and people who used the service wanted to. We saw that the hospital director knew the people who used the service by name and had an understanding of their needs.

Good governance

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.

We saw and staff told us that they received regular training and supervision to undertake their job role. However, some staff told us that there were more training opportunities available at the Northampton site which meant that staff needed to travel to receive this training.

We saw that a sufficient number of nursing staff of the right grades and experience covered the shifts. However, there were insufficient occupational therapists (OTs) employed to ensure that people were engaged in regular activities. OTs told us they were not always supervised because of this. They said these posts were being recruited to.

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

We saw that several people who used the service attended community meetings and were able to express their views. However, we saw in minutes on Northfield ward that a number of requests to improve the ward had been delayed as the ward manager was off sick. Several items noted that the ward manager needed to approve requests on their return to the ward. This meant that people's views had not been actioned to improve the ward for their benefit.

We saw that one person in Speedwell ward had requested that some of their medical information be kept confidential and not shared with all their relatives. The person told us that their confidentiality had been breached and they were upset about this. We found that their request had not been passed to the hospital director who was the Caldicott guardian for the hospital. A Caldicott guardian is a senior person responsible for protecting the confidentiality of a patient and service user information and enabling appropriate information-sharing. This meant that the correct procedures had not been followed to ensure that people's personal information was kept confidential.

We found that the Mental Health Act (MHA) Administrator regularly scrutinised the MHA detention papers.

We saw that the hospital policies for the safe storage of medicines were not followed which could put the safety of people who used the service at risk of harm.

Leadership, morale and staff engagement

Staff told us that they worked as a team and were well supported by managers. They said this enabled them to do their job to benefit the people who used the service. Staff spoken with told us that they felt able to raise any concerns they had without fear of victimisation.

We found that staff on Speedwell ward did not take their breaks as there were not sufficient staff to cover these. They told us that this reduced their morale and led to them feeling unsupported.

Commitment to quality improvement and innovation

Ward managers spoken with told us that the outcomes of directors' meetings were fed into the quality compliance meetings that all ward managers attended. The ward managers then ensured that this was fed back to staff and people who used the service and their responses fed back to the directors. They said that this ensured that the views of people who used the service were listened to. One ward manager told us that they did not receive feedback from audits which meant that they did not know how the service needed to improve.

Nottingham site

Vision and values

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 knew 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.

Are services well-led?

Requires Improvement

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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

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

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.

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

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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.

Essex site

Vision and values

Information about the provider's vision and values were displayed across wards. Staff were kept informed of developments via email and the intranet. Staff reported contact with senior managers in the organisation and that these managers have visited the ward areas. Quarterly staff briefing meetings were held with the hospital director.

Good governance

We found that there were governance systems and meetings at the hospital and within the organisation to review and report for example on incidents, audits and complaints and develop plans for actions needed. Lead staff reported links with managers/peers at other St Andrew's healthcare locations with opportunities to visit have telephone/video conference.

Staff told us that they felt supported in reporting incidents and that lessons learnt were discussed in both individual supervision sessions and within team meetings. 'Think back, move forward' forms were completed by the patient with staff support following an incident. This assisted in reflective thinking and practice.

There were staff resources to deliver training on site and via 'e learning'. Staff reported receiving appraisals. There were systems for staff to receive professional supervision. For example, nursing staff could receive'30:30' managerial supervision (30 minutes every 30 days). Staff referred to 'reflective practice' sessions taking place where staff had the opportunity to discuss with their peers any issue or concerns about people they were working with.

There were opportunities for staff to undertake specialist training as relevant for their work such as emergency and relational security training detailing their role as escort, carrying out observations and search training. Training took place for reducing the risk of self-harm and suicide. We saw that some professionals had opportunities to be involved in learning and development outside of the organisation such as being the chairperson for the specialty doctors committee at the Royal College of Psychiatrists.

Some staff across these wards told us that they considered that there was too much paperwork/bureaucracy which they felt was being cascaded from the central site without understanding how it impacted on the staff and their ability to work with people.

Leadership, morale and staff engagement

Most staff reported receiving good support from line managers and peers. Comments from staff included "it's fantastic, and they [managers] are really supportive". Another "I am happy working here." Another said they got, "exhausted." We noted an increase in staff reporting this in the staff satisfaction survey 2014. Some staff told us that the provider's focus was on "making money." Some senior staff reported a, "controlling organisation" with little ability to influence and to, "bureaucratic processes" within the organisation.

Senior staff told us approximately 60% of people on sick leave were long term and the rest short term. Some staff told us they had been on sick leave within the last three months. The staff survey results reviewed showed that the percentage of staff that reported a slight increase in their health suffering because of work had increased by one percent.

We saw that the provider had systems to refer staff to an occupational health service for advice and support as relevant before returning to work. Staff reported mixed feelings to the level of support they received from management following their return from sick leave.

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.

Staff told us some managers were managing more than one ward and this affected their availability and effectiveness. We saw that management and leadership training was available to staff.

We saw evidence of regular individual supervision meetings and team meetings for staff. Staff told us that they felt their individual supervision meetings were valuable and gave them protected time to discuss personal development and any concerns or issues that they may have. Staff told us that bureau staff did not receive supervision in this role for the provider.

Staff reported they had met with the hospital director at "ask the director" sessions were they could attend and put their views across.

Examples of additional staff feedback systems were when a staff member received a handwritten thank you letter from the chief executive officer acknowledging their work. A senior staff member told us there were 'thank you cards' that could be sent to staff which they had recently used.

A healthcare assistant forum was being developed for the unit and staff were undertaking mentorship training to lead this and support their peers.

Staff referred to case studies taking place where staff had the opportunity to discuss with peers any issue or concerns about people they were working with.

Staff reported that they had been able to raise concerns with managers. For example, they disagreed with staff working long shifts and had been given feedback about the rationale for this. Staff were aware of the whistleblowing policy and told us that they knew how to raise any issues through this process or anonymously via the provider's 'safe call' system.

Most staff reported good peer support. However on Danbury Ward, there had not been a ward manager in post since May 2014. Staff told us that there had not been consistent leadership of this ward despite some managers covering at times.

Staff told us that the high use of agency staff across the wards impacted on team working and this put pressure on the regular staff. Some staff informed us told us they had not received management supervision. However, another staff member told us that they had opportunities to meet directors, executive board members and other visitors to the unit which they felt was valuable.

Commitment to quality improvement and innovation

The hospital director told us they received weekly reports on the quality of the services provided. Key performance indicators and other systems were available at ward meetings for staff to gauge their performance in comparison to other wards in the unit for example for safeguarding, incidents, complaints and absence without leave (AWOL). Information was analysed and also aligned in five domains (safe, effective, caring, responsive and well led).

Out of hours visits by senior staff and unannounced visits from directors took place. We saw reports on the quality and experience and these were fedback to the hospital and to the ward visited**.** Senior staff from wards and department attended quality and compliance groups and action plans were displayed in the unit.

We reviewed the latest staff survey results for the hospital and dated February 2014. This demonstrated to us an increased overall staff satisfaction in most areas. However, we noted that staff reported overall no improvement with communication with senior management.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **How the regulation was not being met:** **In the forensic services the Code of Practice Mental Health Act 1983 was not always being followed.** **In Northampton Sitwell ward was not consistently documenting the patient's review of restraint** **In Northampton Sitwell ward was not following St Andrew's Healthcare Seclusion policy with regard seclusion reviews of patients** **In Northampton Patients' on Fairbairn and Rose wards were not receiving information about their rights in a timescale or format that would aid understanding.** **In Nottingham, blanket searches had occurred without taking into account individual risk and consent** **In the Birmingham services;- The provider must ensure patients are assisted to understand their rights.** **In Nottingham Patients using services had not been provided with a copy of their section 17 forms and leave facilitated.** **Regulation 11 (2) (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **How the Regulation was not being met:**

Compliance actions

On the Birmingham site, the provider should make sure that all staff follow safe medicine management policies, particularly in relation to controlled drugs

Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **How the regulation was not being met:** 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

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:** In Northampton Fairbairn ward staff were being moved off the ward having received training in British Sign Language meaning loss of skilled staff able to communicate with patients. 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.

Compliance actions

There were more agency staff than permanent staff on many shifts.

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.

Records stated that patients were concerned about staff shortages on Rufford ward which had prevented activities taking place and observations not carried ou effectively, and affected patients' mood.

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 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers **How the regulation was not being met:** Patients in the care of the Northampton Men's Service did not consistently have documented discharge plans Regulation 24 (1)(a)