

St Andrews Healthcare

# Neuropsychiatry 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 – Neuropsychiatry service	1-121538260	Althorp ward Tallis ward Tavener ward Berkeley Close Berkrly Lodge	NN1 5DG

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

St Andrew's Healthcare

. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by

St Andrew's Healthcare

and these are brought together to inform our overall judgement of St Andrews Healthcare.

# Summary of findings

## Ratings

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

### Overall rating for Neuropsychiatry service

Good 

Are Neuropsychiatry service safe?

Good 

Are Neuropsychiatry service effective?

Good 

Are Neuropsychiatry service caring?

Good 

Are Neuropsychiatry services responsive?

Good 

Are Neuropsychiatry services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

Care provided within Neuropsychiatric services by St Andrew's Healthcare was safe. Ward environments were clean and hygienic. Staff were aware of their responsibilities regarding safeguarding and people told us they felt safe. Risk assessments were carried out thoroughly for individuals and environments including ligature risk assessments. Staffing was at the levels determined by the organisation. Staff and people on Tallis ward told us that they felt that staffing levels were not meeting the needs of people using the services. We saw that activities had been cancelled due to the lack of availability of staff on Tallis ward. However, staffing levels had been increased immediately prior to our inspection visit.

We found this service to be effective. Information from incidents was collated and staff had a good understanding of recent incidents and learning had followed incidents. We saw changes had taken place following incidents, for example, staffing levels had been increased on Tallis ward. Care was provided within recommended guidelines and the service used specialist outcome measures, including measures it had been involved in developing to monitor the effectiveness of the care and treatment.

Multi-disciplinary teams were based on the wards which ensured people had access to input from psychologists, occupational therapists, physiotherapists, social workers and speech and language therapists as necessary. People also had access to primary healthcare services and their physical healthcare needs were being met.

We found this service to be caring. Most people told us that they were happy with the care which they were provided with and we observed positive interactions between staff and people who used the service. Generally we saw that people were involved in their care planning and the delivery of their care. People had access to advocacy services.

We found this service to be responsive. We noted there was a pathway through the neuropsychiatry services at St Andrew's. Some of the neurological care pathways for specific groups of people, for example, people with Huntington's disease, were continuing to be developed. We noted that some discharges back to local areas had been delayed from the rehabilitation wards. There were some restrictive practices in place, including limited times for smoking breaks and for access to hot drinks.

Overall we found this service to be well led. Most staff we spoke with felt supported by their immediate managers. Some spoke about their work with pride. However, some felt detached from senior management within the provider. The neuropsychiatry services had strong governance structures and clear vision for the future plans. Management had an understanding of where there were risks to this service and were taking action to address these.

# Summary of findings

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

### Are services safe?

Neuropsychiatry services were safe. People were provided with care in clean and hygienic environments.

Staff had a good understanding of safeguarding and made appropriate referrals. Individual and environmental risk assessments were up to date and action plans were developed from identified risks.

Staff were aware of reporting systems and learning from incidents was fed back to inform learning at a service and ward level.

Good



### Are services effective?

Neuropsychiatry services were effective. People had care plans which reflected their medical, psychiatric, nursing and social care needs.

Physical health care was monitored and recorded and people had access to multidisciplinary teams within the provider.

Good



### Are services caring?

Most people we spoke with were positive about the care they received and we observed good interactions between people who used the service and staff. However, there were people on one ward who were less positive about their experiences.

We saw that people were involved in their care planning and people were given the opportunity to feedback to the services.

Good



### Are services responsive to people's needs?

Improvements were required to ensure that these services were responsive. Whilst we noted there was a pathway through the neuropsychiatry services at St Andrew's, one of the neurological care pathways for specific groups of people, for example, people with Huntington's disease, had not been fully developed.

We noted that some discharges back to local areas had been delayed.

We saw that there were some restrictive practices in place, including limited times for smoking breaks and for access to hot drinks.

Good



### Are services well-led?

Neuropsychiatry services had a clear strategic plan for the future. However, some staff felt detached from the leadership of this service and were unclear about the plans for the immediate future. Staff told us that they were able to raise concerns and most felt supported by their line managers.

Good



# Summary of findings

The service had started to use technological approaches to improve the experiences of people who used the service and staff.

# Summary of findings

## Background to the service

The Neuropsychiatry Services are located in Northampton. We visited five ward areas.

Tallis ward which was an admission ward for 15 men with specialist neuropsychiatric conditions.

Tavener ward which was an active rehabilitation ward for up to 16 men with specialist neuropsychiatric conditions.

Althorp ward which was a slow stream rehabilitation ward for up to 19 men with specialist neuropsychiatric conditions.

Berkeley Close and Berkeley Lodge which were rehabilitation wards for 29 and 6 people with neuropsychiatric conditions respectively.

## Our inspection team

Our inspection team was led by:

**Chair:** Stephen Firm, Chief Executive, Oxleas NHS Foundation Trust

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

The team who inspected Neuropsychiatry services was two CQC inspectors, three registered mental nurses (RMN), a Mental Health Act reviewer, an expert by experience and a consultant psychiatrist.

## 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.

## 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 the service, we reviewed information which was provided to us by the charity. We asked for information from other organisations to share what they knew and we carried out focus groups at the St Andrew's site in Northampton.

We carried out an announced inspection between 8 and 11 September. We talked with twenty people who used the service and thirty five members of staff including the Hospital Director, ward managers, Consultant Psychiatrists, Occupational Therapists, Social Workers, Psychologists and qualified and unqualified nursing staff.

We carried out structured observations on one ward to understand the experiences of people who were unable to communicate with us due to cognitive impairments. We also observed interactions on the wards between staff and people who used the service. We reviewed 27 care records and all medication charts on the wards we visited.

# Summary of findings

## What people who use the provider's services say

During the inspection visit we spoke with twenty people who used the service. Most feedback we received was positive. The provider carried out an annual survey of people who used the service. The most recent survey was undertaken between January and February 2014 and the report was published in March 2014.

We looked at the information provided by people who used Neuropsychiatry services at St Andrew's Healthcare.

Out of 160 people on eleven wards within the service, 65 surveys were returned from seven of the wards. Those wards from which responses were received, included Berkeley Close, Berkeley Lodge, Tallis ward, Tavener ward and Althorp ward (under its previous name of Walton). 68% of respondents rated the care they received at St Andrew's as good/very good/excellent while 32% rated the care received as fair/poor

## Good practice

Strong multidisciplinary work on the wards which promoted holistic assessment and treatment of people's needs.

Use of specifically developed outcome measures for people with brain injuries which informed the treatment plans and therapies used in the service.

Introduction of technologies on the ward such as tablet computers to improve the patient and staff experience.

A strong model for future plans of the service meant that at a strategic level it was clear where the development would lie

There were strong internal governance systems within the neuropsychiatry service which meant that managers within the service had a good understanding of the challenges and strengths within the service they were responsible for.

People on Tallis ward had been encouraged to write advanced statements and plan their future care should they lose capacity to make decisions regarding their care in the future.

## Areas for improvement

### **Action the provider MUST or SHOULD take to improve**

The provider should review the use of restrictive blanket practices on wards, for example, specific times for cigarette breaks and drinks on Althorp ward.

The provider should ensure that a review takes place of the mix of patients on Tallis ward where people with Huntington's disease were placed with people with acquired brain injury and ensure the skill mix of staff meets the needs of patients on Tallis ward.

The provider should ensure that specific training is offered in services where it is relevant. For example, around epilepsy and Huntington's disease.

The provider should ensure that people who were not detained under the Mental Health Act (1983) and remain on wards as informal patients should have access to leave without conditions.

## St Andrews Healthcare

# Neuropsychiatry services

## Detailed findings

### Locations inspected

#### Name of service (e.g. ward/unit/team)

Althorp ward  
Tallis ward  
Tavener ward  
Berkeley Close  
Berkeley Lodge

#### Name of CQC registered location

St Andrew's Healthcare – Neuropsychiatry service

### Mental Health Act responsibilities

**We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.**

We spoke with detained and informal patients on all the wards we visited. We also checked records to ensure that the Mental Health Act responsibilities were discharged. We found that staff had a good understanding of their duties under the Mental Health Act (1983)..Staff had received training to understand the Mental Health Act. People were

aware of their rights and had access to advocates. Required paperwork was available to be reviewed and was in order. On Tallis ward we saw that some paperwork had not been checked and we saw two situations which had arisen where people had not been detained lawfully as the paperwork had not been completed correctly. These issues had been resolved at the time of our inspection. However, there was a risk that if paperwork is not checked that people may be at risk of being unlawfully detained.

### Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with demonstrated an understanding of the Mental Capacity Act (2005). We saw that capacity and consent was documented in records and saw good practice where people on Tallis ward were assisted and encouraged to write advanced statements, should they lose capacity to make specific decisions in the future. Some people were subject to Deprivation of Liberty Safeguarding

(DoLS) authorisations and these had been sought, when necessary, from the relevant managing authorities. Ward managers were aware of the procedures to refer someone for an assessment if they felt that someone who was not detainable under the Mental Health Act was being deprived of their liberty.

# 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

Neuropsychiatry services at St Andrew's Healthcare were safe. Care was provided in clean and hygienic environments. Environmental risk assessments including ligature risk assessments were undertaken and identified risks were mitigated on the basis of these assessments.

Staffing levels were determined by the provider and staffing levels were at establishment figures. However, on Tallis ward activities had been cancelled due to the lack of availability of staff. Risk assessments and care plans for people on the wards were thorough and they were regularly updated to ensure they reflected current risks.

Staff were aware of safeguarding procedures and had systems in place which they were aware of, to report incidents and to ensure that information about incidents was fed back to staff and that learning was embedded.

visited. We found they offered a safe environment and met the guidelines stated in the Mental Health Act (1983) code of practice. Most wards had access to resuscitation equipment and emergency medication. However, these facilities were shared between wards and they were not present on Althorp ward.

### Safe staffing

The provider had information about staffing levels and had evaluated establishment numbers of staff using a 'ways of working' model which looked specifically at skills mix of the multidisciplinary teams to ensure that people received the care relevant to their needs.

When additional staff were needed to carry out observations, ward managers were given access to them. St Andrew's had a bureau of staff who worked additional hours to cover any identified staffing gaps.

On Tallis ward however, five staff members identified that they felt there was an issue related to staffing numbers and understanding of needs of people on the ward. We looked at the establishment numbers for Tallis ward and saw that there had been an increase in the staffing levels prior to our inspection visit. In figures provided to us, we saw that there was 1.1 WTE (working time equivalent) vacancy at band 2 level (for a healthcare assistant) and 1.3 WTE vacancy at band 5 (qualified nurse) level.

Feedback from staff on Tallis ward included staff telling us that due to the higher physical care needs of people on the ward, there were fewer staff available to be involved in activities and one of the occupational therapists told us that managing the physical needs of people on the ward meant that less occupational therapy time was available for therapeutic activities. However, staffing levels had recently been increased on this ward.

### Assessing and managing risk to patients and staff

On all the wards we visited, we checked risk assessment information for people who used the services. We looked at 27 records on the five wards we visited. We found that risk assessments were completed comprehensively and were up to date with current information. Information about risk was gathered on admission and frequently updated by multidisciplinary teams. We also checked medicines

## Our findings

### Safe and clean ward environment

We checked the ward environments on the wards we visited. We found that care was provided in a clean and hygienic environment. Infection control audits were carried out regularly on the ward and issues which were identified fed into the action plans available. Environmental risk assessments were undertaken regularly including bi-annual ligature risk assessments. We saw that these assessments identified risks, mitigating actions to be taken and priorities for actions. On some of the wards, such as Althorp ward and Berkeley Close, ligature risks were identified by these assessments. However, these were rehabilitation wards where the risk had been identified as low. This meant that the provider had systems in place to ensure that environmental risks were managed safely.

Althorp ward and Tallis ward had identified blind spots which were managed by increased staff observation and awareness. We checked seclusion facilities on the wards we

# Are services safe?

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

management by looking at the storage, dispensing and recording of medicines. All the records we checked were complete and the systems in place to manage medicines were safe.

Staff had a good understanding of de-escalation techniques which minimised the use of restraint. We saw that there was a provider wide policy which related to seclusion practices and staff we spoke with were aware of this. People had care plans which specifically referred to their needs related to seclusion and restraint when it was needed, which ensured that people's needs were met.

We spoke with the lead social worker for neuropsychiatry services. The provider used the safeguarding matrix used by the local authority to measure the actions taken when incidents related to safeguarding occur on the wards. Social workers were attached to each ward and took a lead on safeguarding. When an incident was logged on the reporting system (Datix) as a safeguarding issue, it was referred to a social worker as well as a ward manager to review. This ensured that safeguarding incidents were reported to external authorities when necessary.

## Reporting incidents and learning from when things go wrong

St Andrew's Healthcare use 'Datix' which is an electronic system to record incidents. All the staff we spoke with across neuropsychiatry services were aware of this system and knew how to report incidents at the ward level. Ward managers and other relevant parties, depending on the type of incident reported. For example, a social worker would be copied into reports concerning safeguarding.

Ward had a 'lessons learnt' file where information was held about learning from incidents across the service. We saw minutes from patient safety meetings which happened regularly at a service level. Neuropsychiatry patient safety meetings fed into broader patient safety meetings across the provider. This included analysis of trends of incidents including a breakdown of incidents to an hourly basis to pick up whether issues were time related. Ward managers and senior managers in the service receive monthly reports which reflect trends and these are collated by the quality and compliance team.

We saw examples on the wards we visited of practices that had changed following incidents. For example, ensuring handover of someone's preferences and needs related to smoking to a new ward when they moved as issues about changing in smoking regimes had led to incidents. We also saw on Tallis ward that incidents which had occurred over a time period had been linked to a shortage of staff so staffing levels had been increased. This showed that the service had embedded learning into the culture.

Information following incidents and related to learning was sent out in emails from the service management. While not all staff had access to emails, folders were present on wards with relevant information. This meant that staff knew how to report incidents and systems were evident which embedded learning from incidents into the service.

# Are services effective?

Good 

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

Neuropsychiatry services at St Andrew's Healthcare were effective. Therapeutic interventions were offered on the basis of thorough and holistic assessments of needs and use of specialist outcome measures which reflected understanding of people with brain injuries and their rehabilitation aims.

Generally we saw that activities programmes were offered on the wards. However, there were fewer structured activities at the weekend. The service used a behavioural therapy system which had been devised by psychologists based at St Andrew's. People had access to support from full multidisciplinary teams. Staff were up to date with mandatory training. Qualified staff received monthly supervision and unqualified nursing staff received regular group supervision and training. Some staff had not received specialist training where they worked in specialist areas.

Staff had a good understanding of the Mental Health Act (1983) and the Mental Capacity Act (2005).

## Our findings

### Assessment of needs and planning of care

We looked at 27 care records across the five wards we visited. The care records we checked indicated that care plans were person-centred and incorporated views of people who used the service where they had capacity to contribute. The records we checked were up to date and provided a rounded understanding of people's needs in relation to their physical and mental health as well as social care needs. For example, on Berkeley Close, the 'this is me' documentation was used which ensured that information about a person's likes and dislike and social history was incorporated into their care plans. On Tallis ward, people had been encouraged to document advanced decisions into the care plan documentation which was particularly helpful for people with degenerative conditions like Huntington's disease and it evidenced people's involvement in planning their own future care.

### Best practice in treatment and care

People working in the neuropsychiatry services had an understanding of current relevant NICE guidelines and we

saw that information was discussed at the management level to ensure that policies on the wards reflected these guidelines. Consultants that we spoke with were aware of the specific prescribing guidelines.

The service used positive behavioural therapy for the rehabilitation of people with acquired brain injury. This was a system devised by psychologists to promote recovery models for people who used the service. However, Tallis ward catered for people who had acquired brain injuries and Huntington's disease. The programmes of support and therapy for people with Huntington's disease were not as fully established as those for people with acquired brain injury. We were told by staff that there was a plan to do 'life story work' with people who have Huntington's disease but this was not happening at the time of our inspection. Life Story Work had commenced on Tallis ward for two patients. One of the therapists on Tallis ward told us that their focus was on rehabilitation of people with acquired brain injuries. This meant that because there was a mix of people on the ward – some who had Huntington's disease and some who had acquired brain injuries, they felt less confident working with people with Huntington's disease. This meant that there was a risk that people admitted to Tallis ward with Huntington's disease may not have their needs met.

The service used outcome measures which had been adapted for people who had brain injuries including the Swansea Neurobehavioral Outcome Scale (SASNOS), The Overt Aggression Scale – Modified for Neurorehabilitation (OAS-MNR) and a St Andrew's Sexual Behaviour Assessment (SASBA). These measures were used to determine the effectiveness of rehabilitation.

Clinicians were involved in clinical auditing. The clinical auditing programme was led by the lead nurses in the service. A recent audit undertaken including one which had been completed related to the use of clozapine to extend research in the area of brain injuries. This meant the audit process was focussed on improvements in patient experience. We saw the 'audit calendar' for neuropsychiatry services which ensured that a strong programme of clinical audit was embedded in the service. However, some staff on the wards were not aware of the clinical audit programmes and the outcomes of these.

### Skilled staff to deliver care

We found that qualified staff received supervision monthly. These sessions were recorded and were audited by ward

# Are services effective?

Good 

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.

managers and senior managers. Staff had received annual appraisals to ensure that their professional development was maintained. Health care assistants attended regular weekly group supervision sessions.

On Tallis ward these included training sessions. We saw minutes of these group supervision sessions and saw that they included issues specific to the wards and allowed staff an opportunity to raise their own issues.

On Tallis ward a training need for specialist training related to Huntington's disease had been identified. An awareness session had taken place and more training was planned. There were no specific training courses relating to epilepsy on Althorp ward where it had been identified as an issue with the user group there. This meant that specialist training specifically related to the user groups within the neuropsychiatry services had not taken place.

Multi-disciplinary teams on the wards consisted of nursing staff, medical staff, health care assistants, psychologists, occupational therapists, technical instructors and social workers. On some wards where the rehabilitation focus was at a specific level, there was access to support from physiotherapists, speech and language therapists. Pharmacists regularly visited the wards.

## **Multi-disciplinary and inter-agency team work**

We observed a multi-disciplinary team meeting on Tallis ward. We saw evidence of strong interdisciplinary working. Professionals attending the meeting had a good understanding of the needs of the people who were being discussed.

All the wards we visited had regular multi-disciplinary team meetings which ensured that information about people on the ward, potential risks and forward plans were shared through the whole team.

On Tallis ward, staff worked on two teams so that staff usually worked with those on the same team. Handovers took place verbally and the information from handovers was not recorded. This meant that there was a risk that important information may not be recorded between shifts.

Some staff told us that when they had made referrals from authorisations under the Deprivation of Liberty safeguards (DoLS) there had been a delay from the relevant local authorities in providing assessors. Most staff told us that they worked well with external agencies and we saw evidence of communication between local mental health teams and the inpatient services at St Andrew's.

## **Adherence to the MHA and the MHA Code of Practice**

We visited most of the wards with a Mental Health Act reviewer who checked documentation related to the Mental Health Act (1983) to ensure that it was in order. Most of the documentation had been completed correctly. We saw on Berkeley Close that the ward social worker had a clear process to determine and establish the current use of the Mental Health Act (1983) and the Mental Capacity Act (2005). However, on Tavener ward, people who were not detained under the Mental Health Act (1983) were required to sign a contract and we saw that there was a form whereby they were 'granted leave' for the grounds and externally. This did not reflect the Mental Health Act (1983) code of practice states "Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward". This meant that there was a risk that people who were not detained under the Mental Health Act (1983) were subject to restrictions on their free movement.

## **Good practice in applying the MCA**

Most staff we spoke with had a good basic understanding of the Mental Capacity Act (2005). It formed a part of the e-learning package that was provided by the provider. We saw that in records on Tallis ward that capacity assessments related to specific issues were recorded and where necessary, best interest decisions were recorded as such which reflected best practice in documenting the use of the Mental Capacity Act (2005). Social workers who led on some of the work related to the Mental Capacity Act (2005) were linked to each ward and provided leadership in the effective implementation of the Mental Capacity Act (2005).

# Are services caring?

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

## Summary of findings

Most of the people we spoke with gave us positive feedback about the care which they received at St Andrew's Healthcare. We generally observed staff ensuring that people's dignity was maintained and providing care in a kind and considerate manner. People received information on their admission to hospital and we saw good examples of involvement in care planning. People's families were involved when it was possible. However, there were some barriers to active involvement due to the distance that some people were away from their families.

## Our findings

### Kindness, dignity, respect and support

We spoke with twenty people who used the service individually and we also spoke to people in a more informal manner when we visited the wards. We also observed care being delivered during our inspection visit. On Tallis ward, where some people had cognitive impairments and all the people on the ward were not able to communicate with us, we carried out structured observations using SOFI (Structured Observation Framework for Inspection).

Most people we spoke with were positive about the care which they received in the neuropsychiatry services. During our visit to Berkeley Close we saw that there were different activities going on. Some of the comments that we received about staff were that they were, "really good" and, "they know how to listen".

During our observations on Tallis ward we observed some positive interactions between staff and people on the ward. However, we noted that some care was delivered in a neutral manner with little interaction between the member of staff and the person who used the service. There were

some chairs in the lounge area below a locked box which contained cigarettes where staff sat away from the sofas and chairs where people who used the service sat. During the mid-afternoon, people were watching the television and sleeping without much evidence of stimulation.

### The involvement of people in the care they receive

Some wards had welcome packs to people who were admitted to the wards which helped to orientate them when they first arrived and information was provided to people before they were admitted to the wards. We saw that people's views were evident in the care plans which we checked.

All the wards had weekly community meetings where people on the ward could raise issues related to the ward. We saw the minutes from these meetings on some of the wards we visited. On Tallis ward we saw the most recent meeting minutes displayed on the ward. However, it was not evident where actions from issues raised at community meetings were subsequently addressed

We observed a ward round on Tallis ward. We saw that people had been involved in discussions about their care needs and that the views of people's families had been sought. People were offered copies of their care plans and we saw that where someone's view differed from those of the care team, that was recorded. This ensured that people's voices were clear in their care planning process.

We saw that a service user survey was undertaken annually. The most recent survey took place in March 2014 and involved the eleven wards in the neuropsychiatry service, five of which we visited. Responses were received from people on Tallis, Tavener, Althorp, Berkeley Close and Berkeley Lodge. The survey explored a number of issues relating to care in detail so that the feedback from people using the service could be collated. It also allowed areas of free text which was included in the survey report. The feedback from the survey was generally positive. However, it identified areas for improvement. This meant that people had the opportunity to provide feedback to the service.

# 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

There was a pathway through the neuropsychiatry services at St Andrew's from admission and assessment to rehabilitation. Some of the neurological care pathways for specific groups of people, for example, people with Huntington's disease were being developed further

We noted that some discharges back to local areas from rehabilitation settings had been delayed. We saw that there were some restrictive practices in place, including limited times for smoking breaks and for access to hot drinks.

Some of the services we visited were provided in wards were in old buildings. Althorp ward had moved about seven weeks prior to our inspection and the change of environment had meant that some facilities, such as en-suite bathrooms, which had been available, were no longer available for people who used the service.

We saw that on Tavener ward informal patients (people who were not detained under the Mental Health Act (1983)) were asked to sign contracts to access leave, which did not reflect guidance in the Mental Health Act code of practice.

Staff on the wards which we visited told us that they had access to interpreters when they were necessary. We saw that the service provided a choice of food including vegetarian food and food which was necessary to meet religious needs.

People had access to some information leaflets in different languages. On the wards we visited we saw information about accessing complaints was on display. We saw that information about complaints was discussed in management meetings within the wards and at ward manager and service level. This ensured that any learning across the service was disseminated.

## Our findings

### Access, discharge and bed management

St Andrew's Healthcare had an established pathway through Neuropsychiatry services. However, some of the pathways for specific groups of people, for example, people with Huntington's disease, were being developed further to meet the needs of the patient groups better.

People were admitted to Tallis ward which was a fast stream rehabilitation/admission and assessment ward. Tavener ward was a fast track rehabilitation ward. Althorp, which had moved wards about seven weeks prior to our inspection, was a slower stream rehabilitation ward. Berkeley Close and Berkeley Lodge were for people at a further stage of rehabilitation before moving back into the wider community. At the time of our inspection, Tallis ward admitted people with acquired brain injuries and Huntington's disease. There was another ward which specialised in more advanced Huntington's disease.

When people were admitted to the wards in the neuropsychiatry service, they and their family members were provided with information. On Althorp ward, admissions were phased with visits. People had 'welcome' packs when they were admitted to the wards which gave basic information.

One person on Tallis ward had moved from Althorp ward because the new ward environment did not meet their needs despite them being more suitable for a slow stream rehabilitation ward. This move was not based on clinical need. Staff and people on Tallis ward told us that they were concerned that the mix of people on Tallis ward where seven people had Huntington's disease and eight people had acquired brain injuries made it difficult for a therapeutic environment to be maintained by staff due to the differing needs and goals of the people on the ward.

There had been an increase in the group of people with Huntington's disease on Tallis ward which had affected the clinical risks on the ward and this was raised as a concern. This had been identified at the clinical advisory group meeting for neuropsychiatry as an issue which needed to be addressed and the need for further training within the staff group had been identified as an action. We saw that there had been an increase in the staffing levels on Tallis ward due to some of the concerns raised. There were plans

# Are services responsive to people's needs?

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

to convert an unused room on the ward into a second lounge area to allow people more different spaces on the ward. This meant some changes were being made to the care provided to increase the responsiveness of the setting.

On Althorp ward we saw that discharge plans were evidenced in care plans. We saw that when people were admitted to the service they had planned phased admissions. 95% of people at Berkeley Close moved from other wards in the hospital and were discharged to residential care, supported living or their own homes. We saw that there were four delayed transfers of care at the time of our inspection visit at Berkeley Close where people were ready to be discharged but did not have any placement to be discharged to. It had been noted in the 'delayed discharge' document provided by the provider that there were 'no active plans for discharge' for three of the four people and for the other one it was noted they 'may move through care pathway to Berkeley Lodge'. This meant that there were not clear plans for some people at Berkeley Close to be discharged.

We saw that weekly there was a meeting within the service regarding admissions and discharges in order to ensure people were receiving the most suitable care. We observed a team meeting on Berkeley Close and saw that admissions and discharges were discussed to try and facilitate and understand the delays in the system.

## The ward environment optimises recovery, comfort and dignity

The ward environments differed significantly between the services we visited. Some wards were based in older building and did not have access to ensuite facilities. Althorp ward had moved about seven weeks prior to our inspection from a ground floor ward where people had unrestricted access to outdoor space to a ward where outdoor space was limited to supervised time. People had previously had access to ensuite facilities and moved to a ward without ensuite facilities. This had had an impact on people who were used to more facilities in their previous ward environment. Refurbishment was taking place during our inspection visit and new furniture was on order.

On Althorp ward and Berkeley Close there were no couches available in the clinic room. This meant that people who needed to be examined would be in their own bedrooms. On Berkeley Close we saw that there were two lounge areas including one which was used as a quiet room. People had access to outdoor space.

Tallis ward had a number of rooms for activities and had a visitor's room. There was access to outdoor space through the lounge and a room had been identified to convert to a new lounge.

On all the wards we visited we saw that there was information on display about activities available and access to advocacy, complaints and local services.

## Ward policies and procedures minimise restrictions

Some wards had blanket policies which affected all the people on the ward. For example, on Berkeley Close the kitchen was locked and patients were reliant on staff to access hot drinks. On Althorp ward, sweets were not allowed and the times that people were able to access hot drinks were restricted to the 'drinks rounds'.

There were also set smoking times on Berkeley Close. These blanket practices meant that there was a risk that care was not responsive to the needs of individuals. When we looked at individual care plans in these wards, we did not see that these restrictions were clearly meeting individual needs. The service had developed some specific guidelines around positive behaviour support for people with acquired brain injuries which were developed by clinical psychologists based on best practice and had been used to reinforce rehabilitation. This ensured that people received appropriate support and guidelines to aid their rehabilitation.

## Meeting the needs of all people who use the service

Staff on the wards which we visited told us that they had access to interpreters when they were necessary. We saw that the service provided a choice of food including vegetarian food and food which was necessary to meet religious needs.

Information was not consistently available in languages other than English. However, there were translation services available.

In the patient survey for St Andrew's we saw that people within neuropsychiatry services had the lowest answer for the question "Do you feel that your spirituality needs have been addressed?" where 46.4% of 67 people who responded within the service answered yes. This was identified as an issue which needed to be addressed following the survey. However, those people we spoke with

# Are services responsive to people's needs?

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told us that they felt their needs were being met in relation to their culture and religion. We saw that there was information on wards about access to multi-faith chaplaincy services.

## **Listening to and learning from concerns and complaints**

Wards had information about how to make complaints on display. Most people we spoke with told us that they knew how to make complaints. We looked at the complaints

which had been made within the service. We saw that there was a central complaints policy. Informal concerns were generally not logged. However, an action plan was developed from the annual survey where people were able to feedback information about the care provided to them.

We saw that information about complaints was discussed in management meetings within the wards and at ward manager and service level. This ensured that any learning across the service was disseminated.

# Are services well-led?

Good 

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

Neuropsychiatry services were well-led. Management within the service had a clear vision of the future path and were aware of the areas which needed to be further developed and improved. There was strong clinical leadership within the service and staff in the service had an understanding of the longer term plans.

There were auditing processes in place to ensure that management had a clear line oversight of performance of the service at ward level and could focus on improvement. Information was shared through the service to ensure that learning took place as a result of audits, incidents and complaints.

Staff morale was mixed. Some staff on the ward level told us that there was little consultation and involvement regarding changes in the service and they knew some changes were happening but were not aware of the details or timescales. This meant that there was a risk of some members of staff feeling they did not have a voice within the organisation. This was particularly notable on Tallis ward.

## Our findings

### Vision and values

Most staff were aware of the senior management within the organisation and particularly the new chief executive who was in post. Some staff told us that they felt proud of working at St Andrew's and were able to reflect on the values of the organisation. However, some staff told us that they felt a detachment with the senior management.

The staff we spoke with were clear about the focus of the wards which they worked on and knew the goals which they were working towards. Staff were familiar with the hospital director within the Neuropsychiatry services who, they told us, was visible on the wards.

### Good governance

Most of the nursing staff we spoke with told us they felt supported by their lead nurses and by the hospital director and clinical director within the neuropsychiatry services.

Governance within neuropsychiatry services had robust checks to ensure that the management had an oversight of

issues on a ward level. There was a bi-monthly clinical advisory group which was attended by lead professionals within the service. We saw the recent minutes of this group and saw that the development of new pathways within the service and a strategic oversight was maintained at this level which fed up to the provider-wide management structure. This also ensured that NICE guidance was integrated into the service planning.

Management within the service was focused on improving the service model for people who used the service and had identified clear plans to do so. This meant that there was an understanding and responsiveness within the governance system to adapt to the needs of people who used the service.

We observed a clinical team management meeting on one ward (Berkeley Close). We noted that information was available at a ward level on key indicators and these included incidents, complaints, supervision and progress and completion on outcome measures including Health of the Nation Outcome Scales (HoNOS).

Ward managers' meetings and lead nurses' meetings took place across the service to ensure both peer support and information sharing took place. Lead nurses took responsibility for auditing and were able to feedback information resulting from audits and human resources issues. Audits resulted in action plans which were available for staff to read via the intranet.

There was a service specific risk register and the managers within the service had a good understanding of where the risks lay and had plans in place to address those issues.

### Leadership, morale and staff engagement

Most staff we spoke with told us they felt supported by their immediate management. We received positive feedback about the hospital director who had come into post earlier in 2014 and was visible on the wards. Staff told us that they felt supported by the hospital director.

Occupational therapists and social workers we spoke with told us that they felt the professional support they received was strong and that the lead professionals within the service and within the provider were supportive and promoted their respective professional groups.

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The hospital manager sends a monthly 'good news' email to all staff within the service to share good practice and identify people who have worked well which promoted morale within the service.

However, on Tallis ward we spoke with staff and found that their morale was lower. Information about the changes in the types of the new admissions to the ward had not been communicated to the staff team and some staff told us that they did not feel support above the ward manager level. Staff told us they knew there were some changes planned but did not know the details and this made them feel unsettled. This meant that their morale was lower and that staff did not feel they were consulted or informed about changes in the service.

All the staff we spoke with across the service told us they felt able to raise concerns and report poor or unsafe practice if they identified it.

## **Commitment to quality improvement and innovation**

We looked at the strategic plans of the service to develop and saw that account had been taken of the use of

technology to improve the experiences of people who used the service and members of staff. For example, on Tavener ward we saw that there was a pilot taking place to use a bed which could monitor some physical health checks electronically. This would ensure more consistent monitoring of physical health needs and free some staff time to improve outcomes.

We saw that the staff were also using tablet computers to monitor outcome measures electronically while on the ward which meant that they saved time by not having to return to a desktop computer, log into the electronic notes system and log the information. This meant that staff had more time on the ward and their time was better used to the benefit of people on the ward.

The service and each ward had an audit schedule which ensured that information from performance indicators was fed into improvement and that the information gathered ensured that information about the ward fed back to drive changes where necessary.