Good

St Andrews Healthcare

Psychiatric intensive care units

Quality Report

Billing Road
Northampton
Northamptonshire
NN1 5DG
Tel: 01604 616367
Website: www.stah.org

Date of inspection visit: 9 - 12 September 2014
Date of publication: 10 February 2015

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 – Men's Service	1-121538205	Sherwood ward	NN1 5DG
St Andrew's Healthcare Essex	1-121538312	Frinton ward	SS12 9JP

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 psychiatric intensive care units	Good 
Are psychiatric intensive care units safe?	Good 
Are psychiatric intensive care units effective?	Good 
Are psychiatric intensive care units caring?	Good 
Are psychiatric intensive care units responsive?	Good 
Are psychiatric intensive care units 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

Contents

Summary of findings

Overall summary

Overall we found that PICU services provided safe, effective, caring, responsive and well led services.

We found that risk assessments were carried out to keep people, staff and the environment safe.

There were systems in place to ensure an effective service. Surveys and audits measured the quality and effectiveness of systems.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided and subsequent discussions with staff.

The services provided were responsive. Evidence was seen that demonstrated to us that the provider encouraged feedback from people and staff to influence the running of the service.

The services provided were well led. Most staff told us that they felt supported. Staff across both wards told us that there were difficulties with recruitment and retention of staff. We found that both units used a number of bureau (St Andrew's healthcare staff) and agency staff to support people.

Summary of findings

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

Are services safe?

Good

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.

We found staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.

Risk assessments and management plans were available for people and the environment to keep them and others safe.

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 to six weeks ahead. Some concerns were identified across both locations about the high use of bureau and agency staff on each unit.

We found that the wards were clean and staff practised safe infection control procedures to minimise the risk of cross-infection.

Are services effective?

Good

Outcomes for people were also assessed through use of the Health of the Nation Outcome Scale (HoNOS) secure assessment tool. A range of therapeutic interventions in line with National Institute for Health and Clinical Excellence (NICE) guidance took place.

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 found effective multi-disciplinary working (MDT) within the service to meet peoples' needs. Both 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 throughout these units and most people we spoke with told us they were aware of their rights.

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 staff had received annual appraisals. We saw examples of additional training being provided for unit based staff.

Summary of findings

We received mixed feedback about the availability of activities at both locations. However systems were in place to monitor this. We found that some staff had difficulty accessing the electronic care and treatment records used in both locations.

Are services caring?

Good

Most people told us staff were approachable and that they gave them appropriate care and support.

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'.

We found that people who used the service were treated with dignity and respect.

Are services responsive to people's needs?

Good

People were referred to the service from within the organisation and externally. Discussions were held on each unit with the clinical team regarding the appropriateness of referral.

The service had access to interpreters when necessary. We saw that information was available about activities and services which were available within each hospital.

Some people told us that the food provided was good. Food was prepared on site and people could choose from a menu.

There was an effective complaints management system in place. 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.

Are services well-led?

Good

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.

The provider had a governance framework in place at each unit 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.

Summary of findings

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 that managers were approachable and they were effective leaders.

The Frinton ward manager was new in post (they had previously been the acting ward manager since February 2014) and worked across two wards.

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

We noted that some action plans detailing the provider's response to direct people's feedback were not available. This meant that it was unclear whether or not they had received a response.

Summary of findings

Background to the service

St Andrew's Healthcare is a charity providing specialist mental health care which was established 176 years ago. The Charity provides services for adolescents and young adults, women, men and older people, with approximately 1000 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 – Mens services Northampton

The twelve bedded psychiatric intensive care unit was being provided on Sherwood ward at this location and was a male only service. During our inspection 12 people were receiving assessment and treatment. Each person was detained under the 1983 Mental Health Act. Accommodation was arranged over two floors.

St Andrew's Healthcare Essex

The twelve bedded psychiatric intensive care unit was being provided on Frinton ward at this location and was a female only service. During our inspection nine people were receiving assessment and treatment. Each person was detained under the 1983 Mental Health Act.

The provider had a total of four outstanding compliance actions from previous Care Quality Commission inspections across both locations. The Commission had received a written action plan from the provider demonstrating how they would achieve compliance with these relevant regulations. This had been updated regularly by the provider. As a result of this inspection we found that the provider was now compliant with these regulations.

Our inspection team

Our inspection team was led by:

Chair: Stephen Firn CEO Oxleas NHS Foundation Trust

Team Leader: Nicholas Smith Head of Hospital Inspection CQC

The team included CQC inspectors and a variety of specialists and experts by experience.

The team that inspected this core service were a CQC hospital inspection manager, three CQC inspectors, a psychiatrist, five specialist senior nurse advisors, four Mental Health Act reviewers, a specialist CQC pharmacy inspector and a senior social worker specialist advisor. The team was divided over two sites and was chosen based on the assessed risks at each location.

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?

Summary of findings

Before visiting these services, we reviewed information which was sent to us by the provider and considered feedback from relevant local stakeholders including advocacy services and focus groups.

We carried out announced visits to these units between 09 and 11 September 2014 and an unannounced visit to Sherwood ward on 25 September. We spoke with ten people who used the service. We reviewed 15 care and treatment records in detail and the relevant prescription charts.

We attended a group based activity, two hospital based morning planning meetings, a handover between night staff and day staff, a clinical team meeting, a hospital wide patient safety and experience group meeting and two clinical reviews with the permission of people who used the service and staff.

We held focus groups with people who were using the service, senior staff and junior staff. We met separately with the lead psychologist, head occupational therapist and lead social worker at each location.

We interviewed four senior hospital managers, both unit based managers, 12 front line staff, support staff and three doctors including the responsible clinicians (RC) for both units.

We reviewed the trust's systems for obtaining feedback from other people who had contact with the service. We also collected feedback using comment cards supplied to the provider by the Commission. This assisted us to obtain a view of the experiences of people who use the services.

The team would like to thank all those who met and spoke to the inspection team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the provider's two locations where this core service was being provided.

What people who use the provider's services say

We spoke with people who used these services provided by this provider 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 that they felt safe on the wards and had good care. They said that staff listened to them and were good at defusing situations which helped people to feel safe.

We reviewed the results of a recent survey carried out on Frinton 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 told us that the food provided was good. Food was prepared on site and people could choose from a menu.

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

- We observed and staff reported good and supportive multi-disciplinary team working.

Summary of findings

- Additional systems were in place to review enhanced support and seclusion/segregation, such as arranging for doctors across wards to give a second opinion/ independent review on the management of these incidents.
- Robust systems were in place for the management and auditing of medicines.
- We found that the monthly patient safety and experience group held at St Andrew's Healthcare Essex was an effective forum for managing and learning from patient safety incidents that took place in the hospital.
- We identified good examples of the provider supporting staff to attend additional training to prepare them to care for people with specific mental healthcare needs.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should review the effectiveness of their current staff recruitment and retention policy and procedures.
- 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 ensure that records of general observations and 15 minute observations on Sherwood ward are accurate and complete where they are necessary.
- The provider should ensure that a written record of all staff handovers is kept on Sherwood ward.
- The provider should review the current practice of blanket restrictions within this core service. 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 the ward manager for Frinton ward was solely managing that unit.
- The provider should ensure that every action plan detailing their response to direct people's feedback are available on the unit.

St Andrews Healthcare

Psychiatric intensive care units

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Sherwood ward	Northampton – Men's Services
Frinton ward	St Andrew's Healthcare Essex

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 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 Act were generally well kept and any concerns identified were shared with and addressed by front line staff during our inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

Whilst all the people who used this core service were currently detained under the 1983 Mental Health Act. We saw that people's mental capacity to consent to their care and treatment had been assessed.

Those assessment and treatment records seen showed us that where people had been assessed as not having the mental capacity to consent to their care and treatment, decisions were made in their best interests. Most staff spoken with demonstrated an awareness of the Act.

Good

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

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.

We found staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.

Risk assessments and management plans were available for people and the environment to keep them and others safe.

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 to six weeks ahead. However some concerns were identified across both locations about the high use of bureau and agency staff on each unit.

Wards were clean and staff practised safe infection control procedures to minimise the risk of cross-infection.

Our findings

Sherwood ward

Safe and clean ward environment

Care was provided in a clean and hygienic ward environment. The ward area had some blind spots which were mitigated by the use of mirrors and observation. We checked the seclusion rooms on the ward. We saw that they were free of ligature points and allowed observations from nursing staff in an adjoining room to be made safely. People who used the seclusion room had access to toilet facilities and there was a clock which was visible to those who were using the room.

One qualified nurse was assigned responsibility for the clinic room. We saw that there were rotas for ensuring the cleanliness of ward areas including clinical areas. A ligature risk assessment had been completed. We saw that work was being undertaken during our inspection visit to manage the identified ligature points according to the risk assessment. The ward had access to outdoor space which was open for 15 minutes every hour. Regular infection control audits were undertaken on the ward and staff had an understanding of infection control issues.

Safe staffing

We saw that staffing was at the prescribed complement which had been decided by looking at the needs of people who used the service.

The ward manager planned rotas about six weeks in advance and ensured that bureau and agency staff were booked in advance as necessary. There were tools on the ward which captured staffing levels on the ward and determined whether additional staff were needed on the basis of the needs of people on the ward due to enhanced observation levels.

Staff told us that when patients needed enhanced support, there could be periods when there were shortages in the staffing. Staff told us that there was a high use of bureau (St Andrew's employed staff) and agency staff particularly at night. Some evidence to support this was seen in those duty rotas examined. Staff told us that the layout of the ward over two floors meant that models used to determine the numbers of staff needed for the ward may underestimate the numbers of staff needed.

There was one full time consultant and one part time consultant allocated to the ward. Medical cover out of hours was reliant on two doctors who covered the St Andrew's site at Northampton. We were told that three members of staff had been injured in the previous three months. These incidents had been reviewed by the provider. Staff received personal security in a secure environment (PSSE) training on induction and PMVA training was given after three months.

Assessing and managing risk to patients

The provider had a system for ensuring that people had risk assessments following admission and regular updates such as the evidence based tool developed by the Institute of

Good

Are services safe?

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

Psychiatry, 'threshold assessment grid' risk screening tool, (TAG). A recently reviewed risk monitoring system was also in place which detailed, for example the access people could have to items in their room and to Section 17 leave off the ward. People's risk level was reviewed and detailed in daily notes.

There were thorough seclusion and restraint management plans for individuals based on their needs. Staff received training in de-escalation skills and conflict resolution. We saw comprehensive seclusion and restraint recording including known physical risks and post-restraint/seclusion care planning for individuals. Physical health checks were undertaken after periods of seclusion.

Reviews took place and we saw that the level of observation changed as people's risks reduced. Unit multi-disciplinary meetings took place to review enhanced support for people giving additional opportunity to review people's care and long term seclusion/segregation.

However, we found that records of general hourly observations and of people who required fifteen minute observations were not fully completed. This meant that there was a risk that information about people who required observation at this enhanced level was at risk of not being available.

Staff were aware of safeguarding procedures and had undertaken mandatory training covering safeguarding issues. There was a social worker based on the ward who took the lead for the ward on safeguarding. The ward had a "lessons learnt" folder on the ward. However, we saw that few staff had signed the information in this folder to evidence that they had read it. This meant that there was a risk that information was provided but that staff did not read it.

A fully equipped clinic room with resuscitation equipment and emergency drugs was available and checked regularly. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that people had access to medicines when they needed them.

Reporting incidents and learning when things go wrong

All staff were aware of the process to report incidents through the 'datix' system used by the Charity and they were able to explain to us how they did so and what happened to reports which they made. Team meetings took place on the ward monthly and learning from incidents formed a part of the discussions which happened regularly. However, meetings for night staff took place on an 'ad hoc' basis which meant that there was a risk that night staff would not have access to the same learning structures as staff that were present during the day.

There was a 'lessons learnt' file held on the ward for staff to read to ensure they had an understanding of issues which had arisen and the learning from them. We were told that staff were encouraged to read these during their regular supervision sessions. However, it was not evident that staff had read these. We saw an example when practice had changed following an incident. This had led to the employment of a nurse who managed the assessed physical healthcare needs of people who used this service.

Frinton ward

Safe and clean ward environment

Environmental risk assessments such as a ligature audit were completed with actions identified as relevant to manage risks. There was a separate seclusion and intensive care unit which allowed clear observation with two-way communication, toilet facilities and a clock. A nursing station had clear visibility of the dining area and partial sight of the lounge area. Each bedroom door had observation panels. There were locked doors and corridors and people were encouraged to spend time out of their room during the day. Some staff reported challenges with the layout of the PICU stating it was not purpose built. However this was not supported by our observations.

The ward was clean, had good furnishings and was well-maintained. For example, there was fixed dining furniture; also specific furniture available in the event of staff needing to use sitting restraint. Strong clothing was available for people where relevant to reduce the risks of people self-harming with clothing. Ward cleaning schedules were in place with audits undertaken by senior staff. One person told us, "it's like a five star hotel."

A fully equipped clinic room with resuscitation equipment and emergency drugs was available and checked regularly. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that people had access to medicines when they

Good

Are services safe?

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

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.

Staff and visitors were given personal alarms when entering the unit and systems were in place to regularly check them. There was a policy for observations and staff recorded checks of people. Some of those records seen were not clear and staff told us this was when people were observed in the communal areas and they would take action to detail this further.

Security policies and procedures were available. Trained dogs could be brought to the ward to search for drugs if required. There was a list of restricted items on the unit to reduce the potential risks of self-harm or harm to others. A procedure was in place for randomly searching staff and people who used the service.

Safe staffing

Dr Hurst's mental health, learning disabilities tool for identifying staffing levels was being piloted in some areas of the charity. This was not being used in the Essex location. The tool is 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. We reviewed the current duty rotas for this ward. We found that there were nine staff on duty caring for ten people, whereas staff told us there were usually six staff on shift (two nurses and four healthcare assistants).

A staff member told us that there were challenges as they were often observing people without a break. This was bought to the attention of the unit manager.

Staff who had worked on the ward before, and who had been trained in the use of restraint were usually requested to ensure consistency of care. An induction checklist, 'Do you know your ward' was available to orientate new staff and we saw examples of these having been completed. We found that agency staff on the unit had only been used since December 2013, as a result of the PICU opening a few months earlier.

Assessing and managing risk to patients

The provider had a system for ensuring that people had risk assessments following admission and regular updates such as the evidence based tool developed by the Institute of Psychiatry, 'threshold assessment grid' risk screening tool, (TAG). A recently reviewed risk monitoring system was also in place which detailed, for example, the access people could have to items in their room and escorted leave off the ward. People's risk level was reviewed and detailed in daily notes. However some did not detail the rationale for decisions made.

There was a clear cut distinction between seclusion and segregation. Reviews took place and we saw that the level of observation changed as people's risks reduced. A monthly unit multi-disciplinary meeting took place to review enhanced support for people. This gave an additional opportunity to review people's care and long term seclusion/segregation. A system was in place to arrange for doctors across wards to give a second opinion/ independent review on the management of individual cases.

People had specific care plans for prevention and management of aggression and violence (PMVA) segregation and advanced statements could be made by people if they wished. PMVA and seclusion record audits took place with actions identified as required. The St Andrew's Healthcare Essex PMVA audit highlighted that improvements were needed for recording such observation levels, support required, patient debriefing and management of lowering mood.

We saw that staff undertook physical observations when people had been given rapid tranquilisation. However there was not one system for identifying where this information was kept as both paper and electronic records

were held. Staff reported challenges with agency staff accessing RiO (patient electronic records). We saw that paper held information about people was not always as up to date as RiO records.

A staff PMVA trainer was on site and gave input into plans. Staff across wards and department told us seclusion and restraint was “a last resort” and the first choice was to use de-escalation techniques. Prone restraint was taught as part of PMVA training and records were kept when this was used with people. Managers confirmed that this practice was currently under review. Staff told us that people would be moved out of a prone position as soon as possible. This was supported by those seclusion and restraint records seen

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. The 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.

Care plans were in place when people were identified as being vulnerable or at risk to others. Monthly multi-agency safeguarding meetings took place with the local authority and the police. Multi-agency public protection arrangements (MAPPA) to review safeguarding incidents and investigations were in place.

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

We reviewed medicines administration records (MAR) on this unit. Appropriate arrangements were in place for recording the administration of medicines. Records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed. If people were allergic to any medicines this was recorded on their medication administration record chart. Medicines interventions by a pharmacist were recorded on the MAR charts to help guide staff in the safe administration of medicines.

A pharmacist visited the ward weekly. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Each patient had a medication profile on the pharmacy information technology system where each medicine had to be clinically approved by a pharmacist before it could be dispensed.

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 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**.** A recent alert from August 2014 highlighted the process to be followed when controlled drugs were delivered to wards. Windows were being replaced across the unit following actions identified after an incident where a person broke one and gained access to the garden. Staff reported that debriefs took place after incidents. A trauma counsellor was accessible to staff where required.

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

Outcomes for people were also assessed through use of the Health of the Nation Outcome Score (HoNOS) secure assessment tool. A range of therapeutic interventions in line withNational Institute for Health and Clinical Excellence (NICE) took place.

We found effective multi-disciplinary working (MDT) within the service to meet people's needs. Both 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 throughout these units and most people we spoke with told us they were aware of their rights.

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 staff had received annual appraisals. We saw examples of additional training being provided for unit based staff

We received mixed feedback about the availability of activities at both locations however we saw systems were in place to monitor this. We noted that some staff had difficulty in accessing the electronic care and treatment records used in both locations.

Our findings

Sherwood Ward

Assessment of needs and planning of care

We checked the care records of people on the ward. The ward used 'my shared pathway' which embedded people's involvement and voice in the care planning process. Risk assessments were completed on admission and reviewed regularly. However, a member of staff told us that they were not always given a person's risk history on admission which could be challenging.

There was evidence of people being involved in their care planning on the recorded care plans. Physical health care was monitored on and during admission to the ward. The ward had established good links with a local GP and practice nurse who attended the ward regularly. People's on-going physical healthcare needs were monitored regularly and this was recorded on the electronic record system.

Best practice in care and treatment

People on the ward had access to 25 hours of activities and contact during the week. We saw an activity session which was received positively by people who used the service. We observed a handover between the night shift and the day shift. The needs of each person on the ward were discussed to ensure that information was shared. However, there was no written handover between shifts. This could mean a potential risk that information may not be shared across different staff groups.

Outcomes for people were also assessed through use of the Health of the Nation Outcome Scale (HoNOS) secure assessment tool. A range of therapeutic interventions in line with the National Institute for Health and Care Excellence (NICE) took place.

Skilled staff to deliver care

There was a full time consultant and part time consultant based on the ward. There was also a full-time occupational therapist, a clinical psychologist, an assistant psychologist and a social worker as well as qualified and unqualified nursing staff. The site had access to a GP who covered the Northampton site and a practice nurse and advanced nurse practitioner as well as podiatry and dentistry which ensured that people's physical healthcare needs were met.

All staff had access to regular supervision and staff had had annual appraisals. We saw that supervision records were up to date. Medical staff had regular peer review meetings monthly to develop clinical role. Staff were aware of the observation policies on the ward. However, while information about people who were on constant observations was comprehensively recorded, the records for people on 15 minute observations and general observations were not complete. Staff were able to explain when patients were subject to searches.

Multi-disciplinary and inter-agency working

There was a multi-disciplinary team on the ward which met weekly. We observed a 'clinical team meeting' on the ward. We saw that the professions present were involved and used their expertise to inform their colleagues. The ward divided into different shifts with staff working a mixture of

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.

'long days and nights'. Handovers between shifts were not recorded which meant that there was a risk that some information may not be shared. When staff needed to link with local teams they did so to ensure that information on admission and discharge was shared. The social worker on the ward liaised with local services and ensured that the relevant information was passed on to local services when people were discharged.

Adherence to the MHA and the MHA Code of Practice

Following our inspection of care records, we saw that, when necessary, assessments were made according to the Mental Health Act. Consent to treatment was recorded on the documentation.

The ward 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. People on the ward did not have access to specific lockable space and they did not have keys to their bedrooms.

Good practice in applying the MCA

The records we checked displayed an understanding of the Mental Capacity Act. Staff undertook training on the Mental Capacity Act which was delivered through e-learning.

Frinton ward

Assessment of needs and planning of care

We reviewed five people's care plans and saw the provider has a standard for assessments taking place within 48 hours of admission. Some staff gave an example of not being provided with a full history about a person before their admission due to information not being shared by previous placement staff. They told us that sometimes this information was likely to have affected their decision to admit the person.

Template "care plan libraries" were available for staff to use. Care plan headings and daily notes reflected the use of recovery tools such as 'my shared pathway' (MSP).

People had a physical health examination and an annual health check with additional assessment and care plans 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 could not access tobacco.

A person returned from an acute hospital following physical healthcare treatment had a care plan in place to safely manage them on return. Systems were in place to communicate key information about people to acute hospital staff.

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 by the multi-disciplinary team.

Best practice in care and treatment

Care plans were available if the person was prescribed clozapine or high dose anti-psychotic medication. Additionally doctors were now using the Glasgow antipsychotic side-effect scale (GASS) assessment to determine if people were suffering from excessive side effects from their antipsychotic medication to help inform care plans. 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 Clinical Excellence (NICE) such as mindfulness and cognitive behavioural therapy took place. We saw evidence of effective use of cognitive behavioural therapy with individuals. This had led to a decrease in incidents including self-harm for individuals.

Additionally groups included using nationally recognised approaches such as STEPPS (systems training for emotional predictability and problem solving). NICE guidelines were referenced for staff to follow for example in policies on chronic disease monitoring and in acute and chronic wound care (for people who self-harm).

The provider had timetables to offer people a weekly minimum of 25 hours therapeutic activity and for tracking attendance. During our visit we saw activities such as karaoke taking place with people. Activities were provided for people who required long term seclusion/segregation.

We received mixed feedback from people about the suitability of activities. A person told us they were "childish"; another told us they were "happy" with them.

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.

Nursing staff undertook weekend activities' and there was an identified activity coordinator. Some staff reported challenges with providing varied activities due to staffing levels and the need for enhanced observations for some people.

We saw the provider had responded to the 2010 National Patient Safety Agency (NPSA) rapid response alert 'reducing harm from omitted and delayed doses' by doing regular audits to check how many doses were omitted or delayed. We saw missed doses were recorded on the provider IT system (Datix) so the provider could check if patients were receiving their medicines as prescribed.

The provider had a central audit team with audits undertaken at provider and location level, for example monthly care plan audits. Each month pharmacy staff completed a comprehensive audit on every ward to check medicines were being managed safely. We saw if any issues were identified an action plan was put in place, with dates for actions to be completed. Recently medicines 'champions' had been nominated on each ward.

Skilled staff to deliver care

Each ward had an identified multi-disciplinary team including doctors (including a consultant psychiatrist), nursing, occupational therapy (OT), 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 staff had received annual appraisals.

Additional training being provided for unit based staff included emergency and relational security training, carrying out enhanced observations and search training. Additionally training took place for reducing the risk of self-harm and suicide. For example, 'knowledge and understanding framework ' training for working with people who had a personality disorder.

Multi-disciplinary and inter-agency working

The ward had shift handovers between each shift. Staff worked long days and reported being given handovers if they were off duty by the nurse in charge if off duty for over three days. New nursing handover sheets related to the relational security explorer, from the 'see, think, act' Department of Health Handbook were seen and had been completed appropriately.

A daily morning planning meeting was attended by staff across wards/department to report key issues for the ward/unit such as staffing, incidents, leave, safeguarding and admissions.

Staff reported regular contact with the multi-disciplinary team (MDT); with regular and effective meetings. For example, MDT staff attendance at the morning community meeting and debrief afterwards.

The provider had systems in place for MDTs to liaise with community team and the care coordinator from the person originating area were invited to CPA review meetings to give feedback on the person's care and treatment.

Adherence to the MHA and the MHA Code of Practice

91% of hospital based staff had undertaken MHA training. The ward 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 procedures were in place for planned and emergency admissions and the records showed us that people had been informed of their rights of appeal against their detention. Staff produced statutory reports where people had appealed against their detention to first tier tribunals and hospital managers' hearings.

We saw there were checks when patients were detained under the Act to ensure that the correct legal documentation for treatment for mental disorder were completed and available. We found no discrepancies between the medicines prescribed and those on the authorised consent forms and there were weekly and monthly checks to ensure these forms were correct.

We identified an issue with detention paperwork for a person and staff advised us of the action they would take to clarify the matter.

Good practice in applying the MCA

91% of hospital based staff had undertaken Mental Capacity Act 2005 training including training relating to deprivation of liberty safeguards (DoLS).

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.

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

Most people told us that staff were approachable and they gave them appropriate care and support.

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'.

We found that people who used the service were treated with dignity and respect.

Our findings

Sherwood ward

Kindness, dignity, respect and support

Most people we spoke with were positive about the support which they received on the ward. We spoke with four people on the ward and observed care being delivered and a group activity on the ward. We observed staff treating people with kindness and respect.

People confirmed that staff treated them with respect and provided support to them. Two people told us that the night staff were less understanding than the staff during the day. This was bought to the attention of senior staff during our inspection.

Staff we spoke with were able to explain to us how they delivered care to individuals which demonstrated that they had a good understanding of the needs of the people who were on the ward.

The involvement of people in the care they receive

A community meeting took place weekly on the ward. People were able to raise concerns and comments during this meeting and these were addressed. For example, we saw that the minutes from the most recent community meeting was on display in the ward. Looking at previous minutes we saw that changes had been made as a result of these discussions. We found that people had asked for a chess set for the ward, which had been purchased.

People received copies of their care plans and this was recorded in their care notes. Weekly meetings took place where patients attended to update their care plans which ensured their involvement. These were recorded effectively in those records reviewed.

Advocates were available on the ward and there was information available in the ward about access to advocacy services. The ward had produced a 'welcome pack' to people who were admitted to the service to help orientate them to the ward.

Frinton ward

Kindness, dignity, respect and support

We observed that staff treated people with dignity and respect. Most people gave positive feedback about the staff group and examples of the kindness of some individual staff. For example one person told us that they were "getting better" on the unit. However, some people expressed their concerns about the attitude of individual staff members. These concerns were bought to the attention of the unit manager.

People received an information pack on admission. A range of information was displayed for people such as health promotion. People had identified keyworkers and opportunities to meet with them, although some people were not clear who their key worker was. People had access to a telephone subject to risk assessment.

The involvement of people in the care they receive

Daily community meetings took place and staff supported people to give their views but also acted as mediator to deal with issues that people raised. People had the opportunity to attend a hospital based 'service user forum'.

We saw evidence of people's involvement in care plans and their views recorded. However this was not evident for those seclusion care plans seen. 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.

We saw clear documentation recording when people had been advised of their legal rights. We saw people could request and had access to independent support to help communicate their needs such as solicitors and staff

Good

Are services caring?

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

responded to this. We saw information publicising the independent mental health advocate (IMHA) service on the unit. This service was based on site with identified ward sessions.

Staff told us that they liaised with people's carers and relatives as agreed with by the person. Staff reported having regular contact with some carers. For example, there were systems to ask people whom they wanted invited to meetings. Carer's needs assessments could be requested from the person's local mental health team.

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

People were referred to the service from within the organisation and externally. Discussions were held on each unit with the clinical team regarding the appropriateness of referral.

The service had access to interpreters when necessary. We saw that information was available about activities and services which were available within each hospital.

Some people told us that the food provided was good. Food was prepared on site and people could choose from a menu.

There was an effective complaints management system being in place. 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.

Our findings

Sherwood ward

Access, discharge, and bed management

People were referred to the ward from within the organisation and externally. Discussions were held on the ward with the clinical team regarding the appropriateness of referral. The management within the hospital wide service also reviewed admissions and delayed discharges from the ward through a regular meeting. We found that people had discharge plans.

The ward environment optimises recovery, comfort and dignity

People had single rooms on an all-male ward. There were shared bathroom and toilet facilities. The ward had a sitting room area and a separate quiet/meeting room where people could spend time. One of the seclusion rooms was used as a 'low stimulation' room if someone chose to spend time away from other people. When it was used for this purpose, the door remained open and the person was able to leave the room whenever they chose.

There was access to outdoor space. The ward also had rooms where activities took place, including a gym area.

People told us that they were satisfied with the meals which they received. We saw that information was available on the ward about activities and services which were available locally.

Ward policies and procedures minimise restrictions

There were periods when access to bedrooms would be limited by locking the door which allowed access to the bedroom areas. This meant that people were restricted in their access to their bedrooms. Some staff told us that this happened because staffing levels did not allow people to be supervised in all areas of the ward during the day. However, it also encouraged people to participate in daytime activities. This appeared to be a blanket policy made on the basis of staffing levels rather than the needs of people on the wards.

There were specific times when people had access to hot drinks. This was six times during the day and into the early evening. However, it meant that people could not have access to hot drinks on demand and could be viewed as a blanket restrictive practice. People gave us mixed responses about their experiences of these restrictive practices. One person told us that they found it difficult that they were not always able to access their bedroom. Another person told us they did not find that this was a problem.

Meeting the needs of all people who use the service

The service had access to interpreters when necessary. We saw that people were offered a variety of meals related to their cultural and religious needs including halal meals, kosher meals and Caribbean meals. There was a chaplaincy service which was multi-faith and was available within the hospital. We saw that the service accessed support from another ward when there was someone who needed a BSL (British sign language) interpreter.

Listening to and learning from concerns and complaints

There was some information about how to make complaints on display on the ward. However, information about how to make complaints was not in the ward welcome pack provided on admission to people. People on the ward told us that they knew how to make complaints.

The ward retained information about complaints on the ward. However, only formal complaints were logged and there was not accessible and immediately available

Good

Are services responsive to people's needs?

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

information about the conclusion of complaints which had been made on the ward. We did not see not a robust system of feedback to people regarding any informal complaints that they might have made. This meant that there was a risk that learning from local complaints was not embedded at ward level.

Frinton ward

Access, discharge, and bed management

During our visit nine women were using the service. There were systems for staff to assess people prior to admission. The hospital director told us that staff tried to assess people within 48-72 hours of referral.

The ward manager said the admission was ward led. Some staff told us that they admitted challenging people when other providers did not want them and that the staff focus was taken up with managing the acutely ill rather than those who were recovering.

Staff told us the average length of stay varied and averaged between six to eight weeks. This was supported by those records reviewed. A weekly unit bed management meeting telephone conference took place with the central St Andrew's Healthcare site to review referrals, admissions transfer and discharges.

Most people were placed from outside the local area from various areas of the United Kingdom. Sometimes a person might be admitted as there was not an identified placement available in their home area and it may be a short time before a bed became available and they were moved back or they might be transferred to a hospital with higher security. Alternatively, people could move to another ward within the hospital when their risks reduced or return to a ward in their home area.

Some staff reported that some people's transfer/discharge could be delayed when there was not an identified placement in their local area or a specialist placement to move to or when there were funding issues which was beyond the provider's control as this was the responsibly of the person's home commissioning team.

The ward environment optimises recovery, comfort and dignity

People did not have community leave due to the acute nature of their mental health and the risks they posed. People had access to fresh air in the garden subject to risk assessment. Agreed visits took place with staff support as required either in the ward meeting room or dining area which staff said was not ideal as there was one meeting room. We noted that the use of vacant bedrooms was being reviewed to consider if they could have additional meeting rooms/therapy space.

A' three item rule' of buying food from the on-site shop/café was made. This was in response to staff concern about people gaining weight and needing to encourage healthy eating.

Ward policies and procedures minimise restrictions

There were periods when access to bedrooms would be limited by locking the door which allowed access to the bedroom areas. This meant that people were restricted in their access to their bedrooms. Some staff told us that this happened to encourage people to participate in daytime activities. There were specific times when people had access to hot drinks.

Meeting the needs of all people who use the service

People had an identified social worker employed by the provider and social work 'drop in' sessions took place for people to meet with them to raise issues such as plans for the future, their finances and family issues. Systems were in place for people who could not easily access their bank to have payment made into an account at the charity so as to give people easier access to their monies during their admission.

Some people told us that the food provided was good. Food was prepared on site and people could choose from a menu. The provider had systems to assess and monitor the quality of the catering 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/refreshment times for people.

There were systems in place to record people's diverse need such as religion and ethnicity. There was a diversity group for staff and the lead social worker told us they were trying to start one for people using the service. However it was unclear how staff were responding to people's diverse requests. One person requested access to an interpreter and wanted information provided to them in their first language which was not English. Another person told us they had previous access to an interpreter but they did not understand them.

Good

Are services responsive to people's needs?

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

Some staff told us the social worker could contact the central Northampton site for services and there was an external agency that provided interpreting services. MHA staff told us that they had access to written information about people's legal rights right for people where English was not their first language. We saw a chaplaincy service was provided on site. Two people told us they had made requests for support with their religious needs and were still waiting for a response, one to meet with an Imam and another to see a Catholic priest.

Listening to and learning from concerns and complaints

Information was displayed on the ward for people to report any 'concerns, complaints, compliments' and there were systems for them to be investigated and complainants to be given a response. There were additional systems for people to raise issues at community meetings. We observed that people felt able to raise with staff a problem about their telephone cards not working and that staff responded appropriately. Information about complaints were reviewed at staff meetings and feedback given on any that were upheld and to minimise any reoccurrence.

There were electronic systems for staff to report any maintenance issues for repair. Maintenance staff were based on site and could respond to emergency repairs. During our visit we noted that the ward office was very warm. Staff expressed frustration that they had reported the matter several times, maintenance work had been undertaken but the problem was not resolved. This was bought to the attention of senior staff during the inspection.

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

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.

The provider had a governance framework in place at each unit 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.

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.

The Frinton ward manager was new in post (they had previously been the acting ward manager since February 2014) and worked across two wards.

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

We noted that some action plans detailing the provider's response to direct people's feedback were not available.

Our findings

Sherwood ward

Vision and values

Staff we spoke with had an understanding of the organisation and the direction in which the provider were going. They told us that they knew senior managers within the wider hospital and received visits from them. For example, there was a schedule of unannounced monitoring visits from management. The ward manager had an understanding of the organisation's vision and values and was able to relate it towards improvements being made on the ward.

Good governance

We spoke with staff on the ward and the lead nurse for the men's services within the mental health pathway which included the PICU ward at Northampton. They explained that information received from incident reporting is fed to senior staff to identify gaps in the service. Reports are generated weekly in relation to incidents including use of restraint and seclusion on the ward. There were specific patient safety groups on a service and charity wide level which ensured that learning was embedded within the organisation.

Ward managers in the service attended a patient safety meeting and then there was a weekly clinical team meeting. The lead nurse had an audit timetable to ensure that areas which can be developed are focused on for improvement. For example, an audit of records and CPA processes had been undertaken. However, the action plans from these audits were not all available on a ward level. Senior management within the service have a schedule of 'out of hours' visits to monitor the quality of the services which are provided. The hospital director provided regular open clinics between 7pm and 9pm which were open for staff to attend.

Leadership, morale and staff engagement

Staff said that the charity was supportive to them and their professional development. The ward manager had been supported by the provider on an NHS nurse leadership programme. Some members of staff told us that there could be a hierarchical feel within the service but most staff felt supported by their immediate line managers. Staff told us that they felt it was a safe place to work and that the teamwork on the ward created a positive environment.

Commitment to quality improvement and innovation

The ward was affiliated with the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU). This is an organization which is involved in promoting and developing work within PICU settings. The ward has also started the process of accreditation with the College Centre for Quality and Improvement (CCQI) which is run by the Royal College of Psychiatrists. The application for full accreditation was currently deferred. However, the ward was committed to addressing the tasks necessary to reach the standards determined and we saw that they had made progress on some of the issues which had been identified.

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.

We spoke with one of the lead psychiatrists for the service who explained that they were developing specific standards for the service based on the evidence base gathered.

We saw that a pilot was being undertaken to use tablet computers to record information so that staff had more time to spend with people on the ward and to ensure that less staff time was taken at desktop computers. There was a mixed response to these but it demonstrated that the service was looking at new ways to approach challenges presented within the ward.

Frinton ward

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 these managers have visited the ward. 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.

There were staff resources to deliver training on site and via 'e learning'. Training leads were based on site and had links with managers and peers across the organisation. The ward manager reported good links with training team. A staff member told us the provider had funded their cognitive behavioural therapy training at university and they had mentorship on site from the lead psychologist. They were currently providing this service to other wards within the hospital.

Staff recieved appraisals and there were systems in place for staff to receive professional supervision. For example, nursing staff could receive'30:30' managerial supervision (30 minutes every 30 days).

In July 2014, 100% of clinical supervision was achieved across the ward. However the ward manger told this was not currently 100% due to staff sickness and annual leave.

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. For example, 'knowledge and understanding framework (KUF) training' for working with people who had a personality disorder was delivered with a person who was using this service.

Some staff across these two units 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

Staff comments included, "it's a nice place to work and rewarding". However another person told us that, "I feel burnt out". During our visit we noted that when the ward was busy; staff were not always available to answer the telephone.

The Frinton ward manager was new in post (they had previously been the acting ward manager since February 2014) and worked across two wards.

We received some positive feedback from staff about their support and leadership although some staff told us the manager was rarely on the ward. Some staff told us there had not been a unit specific manager for some time. We found that deputy ward managers were in post to provide support to the unit manager.

We heard mixed feedback from staff about the level of support given by the provider. Some staff told us that morale was "low", whereas other reported "positive" support and good team working.

Some staff told us that there had been significant staff sickness however this was not confirmed by other staff. Information from the provider indicated that this hospital had the highest staff sickness statistics in the organisation at 7%. We saw the provider had a human resources

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.

department and referred staff to occupational health services where applicable. Staff could have a graduated return to work. The hospital director told us the provider had paid for staff to receive therapy.

The hospital director had identified there were challenges with recruitment and retention of staff for the unit and the provider had plans in place for this. They now offered a recruitment payment to new nursing staff as an employment incentive. The provider conducted exit interviews so as to track reasons why staff may be leaving.

Systems were in place to gain people's views such as in the recent ward 'patient survey' and 'catering survey'. However, the provider actions plans in response to these surveys were not available for inspection. This was bought to the attention of senior staff within the hospital.

We were informed of, 'ask the hospital director' sessions available for staff to meet them and give feedback on issues. There were systems for staff to 'whistle blow 'or to anonymously raise issues via the provider's 'Safe call' system.

Staff told us they could give feedback to senior staff via email. However they told us they did not always get a response or felt there were not always opportunities for further discussions with them.

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 hospital. For example for safeguarding, incidents, complaints and absence without leave (AWOL). Information was analysed and also aligned in the five domains (safe, effective, caring, responsive and well led).

Out of hours visits by senior staff and unannounced visits from directors with reports on the quality and experience were fedback to the ward**.** We found that senior staff from wards and department attended hospital based 'quality and compliance' groups and action plans arising from these meetings 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. We noted that staff reported overall no improvement with communication with senior management.