Care Quality Commission

Birmingham and Solihull Mental Health NHS Trust

Rehabilitation Inpatient 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)
Dan Mooney House	RXT96	Dan Mooney House and David Bromley House	B93 0QA
Eden Unit, Northcroft Site	RXT54	Endeavour Court and Forward House	B23 6AL
Hertford House	RXT27	Hertford House	B92 7JQ
Reaside	RXT64	Ross House	B45 9BE

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health NHS Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health NHS Trust.

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.

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

Birmingham and Solihull Mental Health Foundation Trust provided a range of specialist mental health services through four registered locations: Dan Mooney House, Northcroft, Hertford House and Reaside.

We found that the trust needed to make improvements to ensure that everyone who used the service at Ross House was safeguarded from potential abuse and that the people who used this service were treated with respect and dignity. Throughout the other services visited, we saw that most staff understood how to keep people safe and how to report any issues of concern. We found that staff reported incidents/accidents appropriately. There was a system in place for reviewing and learning from these to prevent them happening again.

The services provided were effective. The service had a clear rehabilitation care pathway. We saw that, across the service, staff worked well in multidisciplinary teams (MDT) to meet people's needs. We also identified good examples of staff working with stakeholders and other partners. This meant that the care and treatment provided was effective. We found that people were having their physical healthcare needs met. Trust wide audits were carried out and staff informed of the outcomes of these. We noted staff vacancies within these services and that these were being covered by trust bank staff.

The trust need to make improvements to ensure that all of these services were caring. We found that most staff were caring and supportive of the people who used the service. Evidence was seen that most people were involved in their own care and treatment. This was supported by those records reviewed and those people spoken with. We saw that people were supported to maintain their independence where they could do and to participate in social and community activities. When we inspected Ross House, we were concerned about the care and treatment being provided to some people on this unit. We brought these to the attention of the trust

The services provided were responsive. We saw some good examples of responsive and person-centred care during our inspection. We noted that there were issues with the funding of placements, community support and finding the correct accommodation. We found that each person discharged from the service left with a trust support package. People told us that they had access to religious and spiritual care. There was an effective complaints management system in place and we found that the trust responded promptly to concerns when they were identified.

The services provided were well led. Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins. We found that local leadership was generally effective and staff reported an open door culture so that they could raise any concerns directly with their manager. They liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO.

Summary of findings

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

Are services safe?
We found that the trust needed to make improvements to ensure that everyone who used the service at Ross House was safeguarded from potential abuse and that the people who used this service were treated with respect and dignity. Throughout the other services visited, we saw that most staff understood how to keep people safe and how to report any issues of concern. We found that staff reported incidents/accidents appropriately. There was a system in place for reviewing and learning from these to prevent them happening again. We found gaps in staffing establishment within some services inspected. Some potential environmental risks on Ross House had not been addressed by the trust.

Are services effective?
The service had a clear rehabilitation care pathway. We saw that, across the service, staff worked well in multidisciplinary teams (MDT) to meet people's needs. We also identified good examples of staff working with stakeholders and other partners. This meant that the care and treatment provided was effective. We found that people were having their physical healthcare needs met. Trust wide audits were carried out and staff informed of the outcomes of these. We noted staff vacancies within these services and that these were being covered by trust bank staff.

Are services caring?
We found that the trust need to make improvements to ensure that all of these services were caring. We found that most staff were caring and supportive of the people who used the service. Evidence was seen that most people were involved in their own care and treatment. This was supported by those records reviewed and those people spoken with. We saw that people were supported to maintain their independence where they could do and to participate in social and community activities. When we inspected Ross House, we were concerned about the care and treatment being provided to some people on this unit. We brought these to the attention of the trust.

Are services responsive to people's needs?
We saw some good examples of responsive and person-centred care during our inspection. We noted that there were issues with the funding of placements, community support and finding the correct accommodation. We found that each person discharged from the service left with a trust support package. Some services also provided an outreach service to people discharged in order to support them with their transition to a new placement.

Summary of findings

People told us that they had access to religious and spiritual care. There was an effective complaints management system in place and we found that the trust responded promptly to concerns when they were identified.

Are services well-led?

Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins. We saw examples of trust wide audits being carried out and reported through local clinical governance arrangements. We found that local leadership was generally effective and staff reported an open door culture so that they could raise any concerns directly with their manager. Staff said that they felt informed about developments within the wider trust. They liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO.

Summary of findings

Background to the service

David Bromley House and Dan Mooney House are purpose built facilities that provide inpatient mental health services for adults aged 18 to 65 years, and are based on one site in Solihull. David Bromley House looks after people with complex care needs and has 14 beds for both sectioned and informal patients. Dan Mooney House cares for people with complex care needs and has 17 beds.

Endeavour Court is a high dependence unit with 14 beds, which looks after the complex care needs of men. Forward House is a 12 bed unit for people with severe and enduring mental health issues. It also provides respite beds for up to six weeks.

Hertford House is a 10 bed unit that provides rehabilitation for people with complex mental health care needs. Ross House is a 13 bed unit for people with severe and enduring mental health issues.

Birmingham and Solihull Mental Health Foundation Trust has been inspected by CQC 10 times since its registration. The trust's wards have also been inspected by Mental Health Act Commissioners. These reports were reviewed before this inspection.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Care Quality Commission (CQC)

The team who inspected these services included: a CQC inspector, a CQC bank inspector, a Mental Health Act commissioner and an Expert by Experience who was a person who had previously used mental health services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme.

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?

We carried out an announced visit to the specialist services of Birmingham and Solihull NHS Foundation Trust from 13 to 16 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff who worked within the service, including nurses, doctors, and therapists. We talked with people who use services, their carers and/or families. We observed how people were being cared for and reviewed their care or treatment records. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 16 May 2014 to Ross House.

Summary of findings

What people who use the provider's services say

People told us that they had had mixed experiences of using the rehabilitation services. Some people told us that there were individual members of staff who had made a positive impact on their mental health recovery, and were kind, caring and treated them with respect.

However, other people told us that they did not always receive a caring and respectful service. They told us that some staff were not always supportive to them and did not contribute positively to their mental health journey.

We saw some good examples of people and their carers being involved in their individual care and treatment, and being given the opportunity to discuss these with their key worker and other staff.

Good practice

- Individualised activity plans that helped people, with support from staff, undertake activities to aid their individual recovery.
- The provision of occupational therapy-led programmes to help people learn the key skills they need for independent living.
- The resettlement team that supported people's transition from rehabilitation services to their new home.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that people are protected from the risk of abuse.
- The trust must ensure that people are treated with dignity and respect.
- The trust should ensure that regular fire evacuation procedural practice takes place for all the units, particularly those that are stand alone.
- The trust should ensure that the environment of Ross House is updated to provide care in a safe and rehabilitative environment.
- The trust should recruit to staff vacancies in the rehabilitation units.
- The trust should ensure that access to data on the trust systems is facilitated for all trust managers.
- The trust should ensure that clear environmental risk audits are carried out throughout this service.

Detailed findings

Birmingham and Solihull Mental Health NHS Trust

Rehabilitation Inpatient Services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Dan Mooney House	Dan Mooney House
David Bromley House	Dan Mooney House
Endeavour Court	Eden Unit
Forward House	Eden Unit
Herford House	Hertford House
Ross House	Reaside

Mental Health Act responsibilities

The use of the Mental Health Act was good in this service. The Mental Health Act documentation reviewed was found to be compliant with the Act and the code of practice in those records inspected.

Care plans, risk assessments and patient involvement were generally documented. Those training records seen showed us that staff had received training on the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) were being used effectively in the areas we visited.

Patient's capacity was discussed as routine in ward reviews There was a clear understanding of the Mental Capacity Act demonstrated by the staff we spoke to and records were appropriately completed by the multi-disciplinary team.

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

We found that the trust needed to make improvements to ensure that everyone who used the service at Ross House was safeguarded from potential abuse and that the people who used this service were treated with respect and dignity. Throughout the other services visited, we saw that most staff understood how to keep people safe and how to report any issues of concern. We found that staff reported incidents/accidents appropriately. There was a system in place for reviewing and learning from these to prevent them happening again. We found gaps in staffing establishment within some services inspected. Some potential environmental risks on Ross House had not been addressed by the trust.

Our findings

Dan Mooney House and David Bromley House

Track record on safety

The service had a clear system for reporting incidents, and information on safety was collected from a range of sources to monitor performance. Staff were able to outline the assessed risks to the people who used this service and, through their assessments and knowledge of each person, felt able to respond to local staffing and emergency situations. We saw a ligature point audit in place to ensure the safety and well-being of people who use the service.

Learning from incidents and improving safety standards

Learning points from incidents were identified and plans put in place to improve safety. Feedback from recent incidents was shared with staff in one-to-one supervision sessions and team meetings. The Deprivation of Liberty Safeguards (DoLS) were used effectively in the areas we visited.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

When we spoke with staff their knowledge of safeguarding was good and they knew how to report and where to raise their concerns. We observed documentation which confirmed that staff had recently undertaken safeguarding training at Level 2 and had completed their AVERTS (Approaches to Violence through Effective Recognition and Training for Staff) training.

Assessing and monitoring safety and risk

We found clear risk assessments were in place for people and these had been reviewed by the multi-disciplinary team. The unit had an observation policy in place which was based on assessed risk. Senior staff informed us that they would increase staff as required if people required enhanced observation for their own safety. We reviewed the observation chart which was regularly completed.

The premises were clean and any maintenance concerns had been addressed. The trust used their own bank staff to address any short term staffing shortages.

Eden Unit (Endeavour Court)

Track record on safety

The service had a clear system for reporting incidents, and information on safety was collected from a range of sources to monitor performance. Staff were able to outline the assessed risks to the people who used this service and, through their assessments and knowledge of each person, felt able to respond to local staffing and emergency situations.

We were unable to obtain access to the data on incidents within the unit. We saw a copy of the incident report which was an overview of the unit trust wide. The incident report did not break down and categorise the data for example, medication errors, AWOL, or behaviour. This meant that staff did not have access to all the information about the incidents that had happened on the unit.

Learning from incidents and Improving safety standards

Senior staff informed us that following a serious incident there would be a review carried out resulting in an action plan. All incidents with action plans were fedback to staff through team meetings and one to one supervision sessions. This was confirmed by those staff spoken with.

We found that there was not the facility on the computerised incident system (Eclipse) to document a person's capacity.

Are services safe?

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

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found good systems in place for keeping people safe and safeguarded from abuse. All the staff we spoke with told us that they received safeguarding vulnerable adults and children training each year. They were able to tell us about their responsibility to refer any potential abusive situations they came across.

Assessing and monitoring safety and risk

We found that the unit was short staffed due to the long-term sickness of two staff and two nurse vacancies. The manager informed us that the staffing shortfalls were addressed by the use of the trust's nurse bank with agency as back-up.

There was good consultant medical cover of the unit each week, with out-of-hours and on-call being addressed by the duty doctor. We were informed that there were occasional delays in getting assistance due to the wide area covered and also because these doctors covered accident and emergency units.

Hertford House

Track record on safety

We reviewed the incident data which was available on the trust's eclipse system. We found that the information contained within the data was sometimes confusing and although we saw the identified outcome we were unable to track the process throughout the system. All the staff we spoke with were aware of incident reporting on the trust's internal computerised system and informed us that incidents were addressed at team meetings. We saw a ligature point audit in place to ensure the safety and well-being of people who use the service.

Learning from incidents and improving safety standards

There were good systems for keeping people safe and safeguarded from abuse. All the staff we spoke with told us that they received safeguarding vulnerable adults and children training each year. They were able to tell us about their responsibility to refer any potential abusive situations they came across.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found that staff knowledge of safeguarding was good and they knew how to report and where to raise their concerns. We observed documentation which confirmed that they had undertaken safeguarding training at Level 2. We noted that staff had access through the trust's intranet system to all policies and procedures that ensured that staff had the required guidance to care for people safely.

We saw the manager completed regular audits on infection control which included the actions taken as a result.

Assessing and monitoring safety and risk

Senior staff informed us that the staffing shortfalls were addressed by the use of the trust's nurse bank with agency as back-up. The consultant visited the unit twice a week with out-of-hours and on-call being addressed by junior doctors. A specialist middle grade doctor was available to support the unit when required. We saw that a pharmacist visited regularly to check that medicines were stored and administered safely.

Forward House

Track record on safety

The service had a clear system for reporting incidents, and information on safety was collected from a range of sources to monitor performance. Staff outlined the assessed risks to the people who used this service. Staff were aware of incident reporting on the trust's internal computerised system and informed us that incidents were addressed at team meetings.

Learning from incidents and improving safety standards

Senior staff informed us that following a serious incident there would be a review carried out resulting in an action plan. All incidents with action plans were fed back to staff through team meetings and one to one supervision sessions. This was confirmed by those staff spoken with.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

There were good systems for keeping people safe and safeguarded from abuse. All the staff we spoke with told us that they received safeguarding vulnerable adults. They were able to tell us about how they were able to report any potential abusive situations appropriately.

Assessing and monitoring safety and risk

Senior staff informed us that the staffing shortfalls were addressed by the use of the trust's nurse bank with agency as back-up. The consultant visited the unit twice a week with out-of-hours and on-call being addressed by junior

Are services safe?

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

doctors. A specialist middle grade doctor was available to support the unit when required. We saw that a pharmacist visited regularly to check that medicines were stored and administered safely.

Ross House

Track record on safety

Staff we spoke with were aware of incident reporting on the trust's internal computerised system and told us that incidents were addressed at team meetings. We were unable to review the incident information on the system as the manager in charge was unable to retrieve this information.

We saw that all policies and procedures had been reviewed and were available for staff on the intranet system.

Learning from incidents and improving safety standards

Senior staff informed us that following a serious incident there would be a review carried out resulting in an action plan. All incidents with action plans were fedback to staff through team meetings and one to one supervision sessions. This was confirmed by those staff spoken with.

However we noted that individual concerns about some staff practice had not been adequately addressed by the trust

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

All the staff we spoke to had completed training in safeguarding vulnerable adults and were able to tell us about the different types of abuse. They told us the action they would take if they saw people living in the home being abused.

However, allegations were made that some people who used this service were experiencing abusive behaviour from two identified staff members and no action had been taken to prevent this happening. An example of the abuse was one person being ordered to sit in the lounge when they wanted to go into the garden. People who were not detained by the 1983 Mental Health Act were having their access to the community limited by the same two identified staff members. We shared this information with senior managers who confirmed they would investigate the issues and address them.

Assessing and monitoring safety and risk

We were told that the unit was currently understaffed. This had an impact on the therapeutic activities being provided. This meant that people were unable to have regular escorted leave into the community. The manager told us that they encouraged staff to put in an incident report regarding each incident of staffing shortfall. The manager told us that over the past three and a half weeks they had been 21 shifts short, which equated to one shift per day short. The unit had current vacancies for two healthcare assistants (HCA) and two nurses. In order to address this shortage the unit used the services of the trust's bank staff or agency staff.

We noted that the corridors within the unit were narrow and enquired as to the risks that this posed to people who used the service and staff. We also enquired about the potential safety risk that a low level wall which abutted the property presented to people who used the service. Senior staff acknowledged that both areas required a risk assessment. They informed us that they were not able to write risk assessment unless it was in conjunction with a risk assessment officer. This was brought to the attention of senior trust staff during our inspection.

Are services effective?

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

Summary of findings

The service had a clear rehabilitation care pathway. We saw that, across the service, staff worked well in multidisciplinary teams (MDT) to meet people's needs. We also identified good examples of staff working with stakeholders and other partners. This meant that the care and treatment provided was effective. We found that people were having their physical healthcare needs met. Trust wide audits were carried out and staff informed of the outcomes of these. We noted staff vacancies within these services and that these were being covered by trust bank staff.

Our findings

Dan Mooney House and David Bromley House

Assessment and delivery of care and treatment

We saw the unit had in place a clear pathway from pre-admission to transition to other services. People had their physical health care needs assessed. We found that the activities planned encouraged people to access individual community provision. We saw that staff supported people to make decisions and choices about community access.

We reviewed three people's care and treatment records in detail. We found that each had a CPA assessment and their care plans had been reviewed and audited. We noted that all health and social care assessments had been updated within seven days of admission. All staff had access to the internal "Insight" system which enabled them to review and amend people's care plans. The system also identified if the patient had signed their care plans. We noted no issues or concerns in those records reviewed.

The staff team meeting minutes identified and recognised that the management of the medication Clozapine required improvement. The records seen showed us that these concerns had been safely addressed by the unit team.

Outcomes for people using services

We saw the unit utilised the non-acute inpatient services (NAIPS) referral pathway. The records we read identified the referring ward and the completed NAIPS assessment which was discussed with the unit prior to the person's admission to this service. The unit used the star recovery model to monitor recovery outcomes for people who used services. Good examples of people and their carers being involved in their individual care and treatment, and being given the opportunity to discuss these with their key worker and other staff.

Staff equipment and facilities

We noted that all staff appraisals were up to date. The manager had a red, amber green (RAG) system in place which would identify when the staffs next appraisal was due.

The unit conducted both clinical and management supervision. The records we looked at identified that staff clinical supervision was low at 50% but that this would be addressed through management supervision which was held bi-monthly.

We found that any staff shortages were being covered by the trust's staff bank. The core unit staff told us that they had received induction and bank staff told us that they were familiar with the unit. The unit's kitchen had been awarded an official rating of grade five for food hygiene. People who used the service were able to cook with staff support.

Multidisciplinary working

Staff confirmed that they worked closely to ensure a clear multi-disciplinary approach towards the assessment of people who were referred to this service. Evidence was seen of multi-disciplinary working to ensure that the recovery star model was effectively implemented. For example through the provision of structured activities and care planning and implementation.

Eden Unit (Endeavour Court)

Assessment and delivery of care and treatment

The manager confirmed that people who used this service had been assessed as being long stay with identified needs. The care pathway for this service was to ensure that people were prepared for eventual discharge to supported living accommodation.

We reviewed two people's care and treatment records in detail. These showed us that each person on the unit had individual risk assessments, care plans and a care programme approach (CPA) assessment. These records had been reviewed and audited. Each person had an individualised activity programme that included use of the activity rooms on the unit.

Are services effective?

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

Outcomes for people using services

The unit used the star recovery model to monitor recovery outcomes for people who used services. Staff outlined this model and described how they worked with people who used this service. Good examples of people and their carers being involved in their individual care and treatment, and being given the opportunity to discuss these with their key worker and other staff. Despite staff reporting effective working with other services we found that there were sometimes difficulties in finding suitable supported living accommodation for people.

Staff equipment and facilities

We were informed that the new manager was going to undertake the task of completing all management supervision whilst clinical supervisions were going to be picked up by the psychologist. Staff confirmed that they were attending mandatory training as required. The current attendance rate was 83%.

We found that any staff shortages were being covered by the trust's staff bank. Staff told us that they had received induction and bank staff told us that they were familiar with the unit.

There were generic environmental risk assessments in place. Those examples seen included; staff stress, needle stick injuries and lone working. We did not see any risk assessment with regard to the pool table.

Multidisciplinary working

We saw that there was effective multidisciplinary working on this unit. Evidence was seen of multi-disciplinary working to ensure that the recovery star model was effectively implemented. For example through the provision of structured activities and care planning and implementation.

Hertford House

Assessment and delivery of care and treatment

We saw the unit had in place a clear pathway from pre-admission to transition to other services. People had their physical health care needs assessed. For example we saw that regular monitoring of people's weight was completed if there was a concern about people's weight and dietary needs.

We saw that each person on the unit had individual risk assessments, care plans and a care programme approach (CPA) assessment. These records had been reviewed and audited.

Outcomes for people using services

The unit used the star recovery model to monitor recovery outcomes for people who used services. Staff were able to outline this model. We saw the unit utilised the non-acute inpatient services (NAIPS) referral pathway. Good examples of people and their carers being involved in their individual care and treatment, and being given the opportunity to discuss these with their key worker and other staff.

Senior staff informed us that whilst discharges were much quicker than before but they were still having issues with funding and finding the correct accommodation with the average stay of approximately eight months.

Staff equipment and facilities

We saw a good mix of qualified and unqualified staff on the unit. Staff we spoke to told us they were very well supported and received regular management, clinical and group supervision. The manager delivered management supervision, whilst staff chose as per trust policy their own clinical supervisor.

We noted that all staff appraisals were up to date. The manager had a red, amber green (RAG) system in place which would identify when the staffs next appraisal was due.

We found that any staff shortages were being covered by the trust's staff bank. Staff told us that they had received induction and bank staff told us that they were familiar with the unit.

There were generic environmental risk assessments in place. Those examples seen included needle stick injuries and lone working. The fire risk assessment we observed was due for review. The staff said that the fire alarm sounder was carried out weekly. However, we found that there were no provision in place for evacuation of the unit in the event of an emergency.

Multidisciplinary working

We saw that there was good multidisciplinary team working in the unit, with the consultant visiting the unit twice per week to chair a review of people's progress. People were able to invite anyone involved in their care to the review meeting.

The records seen showed us that people were able to discuss their progress and treatment. One person told us that the doctor always discussed their medication with them so they understood what they were taking and why.

Are services effective?

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

Forward House

Assessment and delivery of care and treatment

We saw the unit had in place a clear pathway from pre-admission to transition to other services. People had their physical health care needs assessed. For example we saw that each person was registered with a General Practitioner. Staff confirmed that people would be supported to attend the surgery as required.

We saw that each person on the unit had individual risk assessments, care plans and a care programme approach (CPA) assessment. These records had been reviewed and audited. There were clear handovers at each shift change which included an overview of each patients and if there any issues or concerns.

Outcomes for people using services

We saw the unit utilised the non-acute inpatient services (NAIPS) referral pathway. The unit used the star recovery model to monitor recovery outcomes for people who used services. Staff outlined this model and showed us examples in those records reviewed. We saw examples of individualised 'goal planning' for people. We noted that each person received a support package from the trust upon discharge.

Staff, equipment and facilities

Staff told us they were well supported by their liner manager and received regular management, clinical and group supervision. The manager delivered management supervision, whilst staff chose their own clinical supervisor.

We found that any staff shortages were being covered by the trust's staff bank. Staff told us that they had received induction and bank staff told us that they were familiar with the unit.

There were generic environmental risk assessments in place. Those examples seen included fire risk assessments and access to and the use of the kitchen.

Multidisciplinary working

We saw that there was good multidisciplinary team working in the unit, with the consultant visiting the unit once a week to chair a review of people's progress. The records seen showed us that people were able to discuss their progress and treatment. One person told us that the doctor always discussed any concerns that they may have with them.

Ross House

Assessment and delivery of care and treatment

We saw the unit had in place a clear assessment and treatment pathway from pre-admission to transition to other services. Staff on the unit utilised the MOHOST (model of occupation therapist screen tool) and the NAIPS suite of assessments to assess the level of care input required for each person.

The records seen showed us that staff were assessing each person individually. However we looked at the care plans of three people and saw that these did not reflect the assessed needs of the person concerned The care plans reviewed provided no guidance or direction to support the rights and needs of the person by staff. This was brought to the attention of senior staff during the inspection.

People had their physical health care needs assessed. For example we saw that each person was registered with a General Practitioner. Staff confirmed that people would be supported to attend the surgery as required.

Outcomes for people using services

The unit used the star recovery model to monitor recovery outcomes for people who used services. Staff outlined this model and showed us examples in those records reviewed. We saw examples of individualised 'goal planning' for people. We noted that each person received a support package from the trust upon discharge.

The length of stay for people who use the service was variable ranging from three months to 12 years. We were informed that finding discharge placements for some people was difficult and support was being sought from third sector providers.

Staff, equipment and facilities

We found that any staff shortages were being covered by the trust's staff bank. Staff told us that they had received induction and bank staff told us that they were familiar with the unit.

There were generic environmental risk assessments in place. Those examples seen included fire risk assessments and access to and the use of the kitchen. We saw copies of completed local audits and noted that action to address any identified concerns had been identified.

Are services effective?

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

Multidisciplinary working

The records seen showed us that the Multi-disciplinary team worked alongside staff to maintain a rehabilitation programme dependant on the needs of the patient. This programme was reviewed, and individual progress was documented within the three monthly CPA meetings.

Are services caring?

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

Summary of findings

We found that most staff were caring and supportive of the people who used the service. Evidence was seen that most people were involved in their own care and treatment. This was supported by those records reviewed and those people spoken with. We saw that most people were supported to maintain their independence where they could do and to participate in social and community activities. When we inspected Ross House, we were concerned about the care being provided to some people on this unit. We brought these to the attention of the trust.

Our findings

Dan Mooney House and David Bromley House

Kindness, dignity and respect

We saw that each person who used the service received a "Welcome" leaflet on arrival at the units. The leaflet contained information regarding approaches and interventions to support their needs as well as information about visiting times and house rules which included a zero tolerance policy to physical and verbal abuse and that all staff, other people who used the service and visitors were to be treated with mutual respect.

We noted that staff were treating people with kindness and respect. Adaptations had been made to meet the needs of a person with impaired mobility. The manager informed us that they were in the process of creating a "quiet space" for people to sit and reflect.

The service had a lead 'dignity' nurse who was available to hear and discuss the needs of people. People's religious beliefs were taken into account and a room had been set aside for them to pray and reflect.

People using services involvement

People we spoke to knew about their care plans and said they had agreed to the plans by signing them. This was evidenced by those three care and treatment records that we examined. The care plans reviewed provided guidance for staff on how to meet the individual needs of the person who used the service. Each person had an individual activity programme which identified their current needs.

We saw a copy of a "how are we doing" breakdown for this service. We noted that how patients "felt they were listened to" and "how they were respected" were at 79% and 77% respectively.

Emotional support for care and treatment

We saw staff communicating effectively with people and using different communication methods where appropriate. Staff were supportive and encouraged people who used the service to be as independent as possible.

Endeavour Court

Kindness, dignity and respect

We noted that staff were treating people with kindness and respect. The people we spoke with confirmed that staff were helpful towards them. We saw that staff responded to people's requests in a timely way and showed a clear understanding of people's needs.

People using services involvement

We saw some good examples of people and their carers being involved in their individual care and treatment, and being given the opportunity to discuss these with their key worker and other staff. People we spoke to knew about their care plans and said they had agreed to the plans by signing them. This was evidenced by those care and treatment records that we examined. The care plans reviewed provided guidance for staff on how to meet the individual needs of the person who used the service. Each person had an individual activity programme which identified their current needs.

We saw on the notice board a "you said we did" poster. This provided a breakdown of issues raised by people on the unit and what the service had done to address it. Examples included the moving of a water unit which subsequently became accessible to all people.

Emotional support for care and treatment

We saw staff communicating effectively with people and using different communication methods where appropriate. We saw that people were supported to maintain their independence where they could do and to participate in social and community activities.

Hertford House

Kindness, dignity and respect

We noted that staff were treating people with kindness and respect. This was supported by four people spoken with. They told us they were treated respectfully by all staff at the unit and they felt their privacy and dignity was maintained

Are services caring?

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

at all times. We had a walk around the unit and noted that some of the communal room windows did not have curtains. This potential dignity issue was brought to the attention of senior staff during our inspection.

People using services involvement

People we spoke to knew about their care plans and said they had agreed to the plans by signing them. One person said they had not read their care plans but signed because they had been asked to. We spoke to the manager about this and they addressed this right away by ensuring that a key worker reviewed the content of the care plan with the person concerned.

We were told that there are community meetings with people living in the unit. However, there were no minutes taken. Senior staff were looking at introducing a newsletter which would replace the minutes.

Emotional support for care and treatment

Some people told us that staff talked to them like a person and were not judgemental. We saw that staff spent time talking with and listening to people. Staff spoken with showed an understanding of people's individual emotional needs and how they needed to support people to meet these.

Forward House

Kindness, dignity and respect

We noted that staff were treating people with kindness and respect. This was supported by those people spoken with. They told us they were treated with kindness by staff at the unit. We saw that staff responded promptly to people's requests and showed an understanding of individual needs.

People using services involvement

People we spoke to knew about their care plans and said they had agreed to the plans by signing them. A weekly community meeting was held and the minutes seen showed us that the service had made changes in response to people's concerns. For example we noted a review of the weekly communal shopping trips following feedback from people.

Emotional support for care and treatment

One person told us that if they were upset staff sat with them and talked about it. We found that staff spent time talking with and listening to people. Staff spoken with showed an understanding of the individual support needs of those people who used the service.

Ross House

Kindness, dignity and respect

We saw staff treating people with respect and kindness during the inspection. However, we were informed that people were not always treated with respect by some staff. An example of this was people being shouted at and ordered to sit in the lounge. Some people told us that they did not always receive a caring and respectful service. They told us that some staff were not always supportive to them and did not contribute positively to their mental health journey. These concerns were brought to the attention of senior trust staff during the inspection.

The unit had a diversity lead that looked at the spiritual needs of people who used the service and would bring in posters to support this. Currently it was identified that the unit needed to purchase a prayer mat to support people's religious beliefs and practice.

People using services involvement

Some people told us that they were not involved their care and treatment. The records seen did not show us evidence of the active involvement of people in their own care and treatment. Other people told us that certain staff members had involved them in some aspects of their care.

The record seen showed us that community meetings were held on the unit. However there was no evidence that any issues raised had been effectively addressed by staff.

Emotional support for care and treatment

Those care plans seen did not reflect how people's emotional needs would be met by staff. Some people told us that they were supported by staff to access the community. For example, we saw an individual activity programme which identified their current activity provision.

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

We saw some good examples of responsive and person-centred care during our inspection. We noted that there were issues with the funding of placements, community support and finding the correct accommodation. We found that each person discharged from the service left with a trust support package. Some services also provided an outreach service to people discharged in order to support them with their transition to a new placement.

People told us that they had access to religious and spiritual care. There was an effective complaints management system in place and we found that the trust responded promptly to concerns when they were identified.

Our findings

Dan Mooney House and David Bromley House

Planning and delivering services

The units had a proactive discharge planning system in place. This system worked alongside the multidisciplinary team (MDT) and utilised the services of an occupational therapist and a psychiatrist. The unit worked with people regarding where they might be supportively discharged to. We found that this was recorded in people's care and treatment records.

There was a central referral system group that met twice a month, which we were told made for a "smoother transition." The manager informed us discharges were much quicker than before. However we noted that there were issues with the funding of placements, community support and finding the correct accommodation.

Staff informed us that accommodation issues and funding for these individuals had a detrimental effect on the prompt and appropriate discharge of patients. We noted that one person had been within the service for ten years and the trust were currently in the process of trying to identify suitable supported accommodation for them.

Care pathway

We saw that this service had discharged ten people over the last year. The service also provided an outreach service to people discharged in order to support them with their transition to a new placement.

This had enabled the service to admit other people who required longer term rehabilitative care and treatment.

Right care at the right time

The records seen showed us that people's needs were fully assessed upon admission to the service. For example we saw the unit utilised the non-acute inpatient services (NAIPS) referral pathway. The records we read identified the referring ward and the completed NAIPS assessment which was discussed with the unit prior to admission. People told us that they had access to religious and spiritual care.

The care and treatment plans showed us that people were having their care plans reviewed and discussed by the multi-disciplinary team in line with their needs assessment. The service had a good handover system which was conducted three times a day. Any issues or concerns were identified and discussed during the handover.

Learning from concerns and complaints

People told us that they knew how to make a complaint. They said that when they had made a complaint this had been investigated and action was taken to resolve their concerns. People told us they had the information they needed to know how to access an advocate.

People had access to the patient advice and liaison service (PALS) leaflet which we noted was in an easy to read format. This provided them with information about accessing this service.

Staff informed us that complaints were taken seriously by the trust and we saw some evidence of actions having been taken in response to these.

Endeavour Court

Planning and delivering services

We found that care reviews were held every six months with the multi-disciplinary team and the person who used the service, although we did not find evidence of proactive discharge planning in place.

We noted that there were issues with the funding of placements, community support and finding the correct accommodation.

Are services responsive to people's needs?

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

Staff informed us that accommodation issues and funding for these individuals had a detrimental effect on the prompt and appropriate discharge of patients. We were told that length of stays were on average between 12 and 18 months. The main concerns were finding the correct accommodation to suit the needs of people.

Care pathway

Access to the service was via referrals from other trust services. Assessment care plan and treatments were reviewed and evaluated. We found that each person discharged from the unit left with a support package.

Right care at the right time

The records seen showed us that people's needs were fully assessed upon admission to the service. For example we saw the unit utilised the non-acute inpatient services (NAIPS) referral pathway. The records we read identified the referring ward and the completed NAIPS assessment which was discussed with the unit prior to admission.

The care and treatment plans showed us that people were having their care plans reviewed and discussed by the multi-disciplinary team in line with their needs assessment. People told us that they had access to religious and spiritual care through a contact of their choice. They told us of a recent a memorial service that had been held in the garden for a person who had died.

Learning from concerns and complaints

People told us that they knew how to make a complaint. They said that when they had made a complaint this had been investigated and action was taken to resolve their concerns. People told us they had the information they needed to know how to access an advocate. People told us that they found the advocacy service to be helpful.

People had access to the patient advice and liaison service (PALS) leaflet which we noted was in an easy to read format. This provided them with information about accessing this service. We noted that complaints were reviewed at staff meetings and the lessons learnt discussed with staff.

Hertford House

Planning and delivering services

Those records reviewed showed us that the service was planning discharges with the involvement of the person who used the service.

We noted that there were issues with the funding of placements, community support and finding the correct accommodation for people. We were informed discharges were much quicker than previously but they were still having issues with funding and finding the correct accommodation with the average stay of approximately 8 months.

Care pathway

Access to the service was via referrals from other trust services. Care and treatment records were reviewed and evaluated. We found that each person discharged from the unit left with a support package.

Right care at the right time

The records seen showed us that people's needs were fully assessed upon admission to the service. The care and treatment plans showed us that people were having their care plans reviewed and discussed by the multi-disciplinary team in line with their needs assessment. People told us that they had access to religious and spiritual care.

Learning from concerns and complaints

People told us that they knew how to make a complaint. They said that when they had made a complaint this had been investigated and action was taken to resolve their concerns. People told us they had the information they needed to know how to access an advocate. People told us that they found the advocacy service to be helpful.

People had access to the patient advice and liaison service (PALS) leaflet which we noted was in an easy to read format. This provided them with information about accessing this service. We noted that complaints were reviewed at staff meetings and the lessons learnt discussed with staff.

Forward House

Planning and delivering services

We found that care reviews were held every six months with the multi-disciplinary team and the person who used the service, although we did not find evidence of proactive discharge planning in place.

We noted that there were issues with the funding of placements, community support and finding the correct accommodation.

Staff informed us that accommodation issues and funding for these individuals had a detrimental effect on the

Are services responsive to people's needs?

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

prompt and appropriate discharge of patients. We were told that length of stays were on average between 12 and 18 months. The main concerns were finding the correct accommodation to suit the needs of people.

Care pathway

Access to the service was via referrals from other trust services. Assessment care plan and treatments were reviewed and evaluated. We found that each person discharged from the unit left with a support package.

Right care at the right time

The records seen showed us that people's needs were fully assessed upon admission to the service. For example we saw the unit utilised the non-acute inpatient services (NAIPS) referral pathway. The records we read identified the referring ward and the completed NAIPS assessment which was discussed with the unit prior to admission.

The care and treatment plans showed us that people were having their care plans reviewed and discussed by the multi-disciplinary team in line with their needs assessment. People told us that they had access to religious and spiritual care.

Learning from concerns and complaints

People told us that they knew how to make a complaint. They said that when they had made a complaint this had been investigated and action was taken to resolve their concerns. People told us they had the information they needed to know how to access an advocate. We noted that formal complaints were reviewed at staff meetings and the lessons learnt discussed with staff.

Ross House

Planning and delivering services

Those records reviewed showed us that the service was planning discharges with the involvement of the person who used the service.

We noted that there were issues with the funding of placements, community support and finding the correct accommodation for people. We were informed discharges were much quicker than previously but they were still having issues with funding and finding the correct accommodation with the average stay of between three and twelve months.

Care pathway

Access to the service was via referrals from other trust services. Care and treatment records were reviewed and evaluated. Some care plans had not been reviewed to reflect changes in assessed need. We found that each person discharged from the unit left with a support package.

Right care at the right time

The multi-disciplinary team worked alongside staff to maintain a rehabilitation programme dependant on the needs of the people who used the service. This programme was reviewed, and the patient's progress documented within the three monthly CPA review meetings.

Learning from concerns and complaints

Some people told us that they knew how to make a complaint. They said that when they had made a complaint this had been investigated. People told us they had the information they needed to know how to access an advocate. We noted that formal complaints were reviewed at staff meetings and the lessons learnt discussed.

Are services well-led?

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

Summary of findings

Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins. We saw examples of trust wide audits being carried out and reported through local clinical governance arrangements. We found that local leadership was generally effective and staff reported an open door culture so that they could raise any concerns directly with their manager. Staff said that they felt informed about developments within the wider trust. They liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO.

Our findings

Dan Mooney House and David Bromley House

Vision and strategy

Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins. They told us that they felt engaged by the recent changes within the trust.

Responsible governance

The manager had a "how are we doing" local breakdown for the unit. Questions asked included have you been offered a copy of your care plan and therapeutic observations. We noted that the unit's percentage was variable from 100% to 43%. An action plan was in place to address any identified concerns.

The unit also had an implementation completion report (ICR). Areas covered included; assessment summary, inpatient care plans and MDT reviews. The report did not highlight any issues or concerns.

We saw examples of trust wide audits being carried out and reported through local clinical governance arrangements.

Leadership and culture

We found that local leadership was effective and staff reported an open door culture so that they could raise any concerns directly with the manager.

Staff told us that the appointment of the new CEO had made a real difference to morale on the units. The CEO had visited three times and members of the executive board had also been to the units to meet staff and people living there.

The weekly communication from the CEO was well received by staff who said they found this a 'dynamic' innovation. The manager felt this had had an impact on staff and they felt more comfortable with how things were progressing.

Engagement

Staff told us they felt that the trust was more open and honest than in the past. Staff said that they liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO. Staff reported that they "felt listened" to.

We observed within the staff room posters which outlined the trust's values, dignity and respect. We saw posters of "who are we", "what do we stand for "and where we are going", "how do we get there" and "how involved." We saw the "Dear John'' scheme was displayed on posters around the units, this encouraged staff to make contact with issues either anonymously or openly.

Endeavour Court

Vision and strategy

Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins. They told us that they felt engaged by the recent changes within the trust.

Responsible governance

The unit had an implementation completion report (ICR). Areas covered included; assessment summary, inpatient care plans and MDT reviews. The report identified that MDT reviews were currently at 70% whilst inpatient care planning was at 80%.

We saw examples of trust wide audits being carried out and reported through local clinical governance arrangements.

Leadership and culture

Staff reported effective local leadership. Staff meeting minutes were in place which provided guidance and a discussion on the Deprivation of Liberty Safeguards (DoLS). Also identified were guidance on guardianship, community treatment orders (CTO) and conditional discharge. We noted there was a read and sign sheet attached once staff had read the literature attached to the minutes. Appraisals, clinical and managerial supervisions were up to date

Are services well-led?

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

Staff told us that the appointment of the new CEO had made a real difference to the trust. The weekly communication from the CEO was well received by staff.

Engagement

Staff told us they felt that the trust was open and honest. Staff said that they liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO. Staff reported that they "felt listened" to.

We observed within the staff office posters which outlined the trust's values, dignity and respect. We saw the "Dear John'' scheme was displayed on posters around the units, this encouraged staff to make contact with issues either anonymously or openly.

Hertford House

Vision and strategy

Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins.

Responsible governance

The unit had a "how are we doing" breakdown for the unit. Questions asked included have you been offered a copy of your care plan and therapeutic observations. We noted that the unit had a percentage of 100% for all questions asked. The unit also had an Implementation Completion Report (ICR). Areas covered included; Assessment summary, inpatient care plans and MDT reviews. The report had not highlighted any issues or concerns.

We saw examples of trust wide audits being carried out and reported through local clinical governance arrangements.

Leadership and culture

Staff reported effective local leadership and staff reported an open door culture so that they could raise any concerns directly with the manager.

The unit had recently had a "See Me" (Service user development team) visit. We saw the feedback which was positive with no issues or concerns raised. Staff were able to raise their concerns anonymously through the trusts "Dear John" scheme. We noted there were posters outlining the scheme within the staff office. The weekly communication from the CEO was well received by staff.

Engagement

Staff told us that information from the trust was being filtered down slowly and the culture felt more open and less blaming.

Staff said that they liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO.

Forward House

Vision and strategy

Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins. Some staff told us that they were involved in the recent trust changes.

Responsible governance

The unit had an implementation completion report (ICR). Areas covered included; assessment summary, inpatient care plans and MDT reviews. We noted that no concerns had been identified

We saw examples of trust wide audits being carried out and reported through local clinical governance arrangements.

Leadership and culture

Staff reported effective local leadership. Staff meeting minutes were in place which provided guidance and discussions on recent professional updates. Appraisals, clinical and managerial supervisions were up to date. Staff told us that the appointment of the new CEO had made a real difference to the trust.

Engagement

Staff said that they felt informed about developments within the wider trust. They liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO.

We observed within the service posters which outlined the trust's values, dignity and respect. We saw the "Dear John'' scheme was displayed on posters around the units, this encouraged staff to make contact with issues either anonymously or openly.

Ross House

Vision and strategy

Staff were aware of the trust's vision and strategy through the trust's intranet and other bulletins. Some staff told us that they were aware of the recent trust changes.

Responsible governance

We saw copies of the audits completed by the manager. Examples included; food service audit, infection control and health and safety.

We saw examples of trust wide audits being carried out and reported through local clinical governance arrangements.

Are services well-led?

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

Leadership and culture

Some staff felt the manager was making good changes and providing leadership however there were allegations that some staff did not engage with the changes and improvements that were being brought to the service. The weekly communication from the CEO was well received by staff.

Engagement

Staff told us they felt that the trust was open. Staff said that they liked the "listening into action" scheme whereby they were invited to put their ideas forward and speak with the CEO. Staff reported they "felt listened" to.

We observed within the staff room posters which outlined the trust's values, dignity and respect. We saw the "Dear John'' scheme was displayed on posters around the units, this encouraged staff to make contact with issues either anonymously or openly.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must take proper steps to ensure that each person is protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1) (b) (i) (ii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must make suitable arrangements to ensure that each person is safeguarded against the risk of abuse by means of • taking steps to identify the possibility of abuse and prevent it before it occurs and • responding appropriately to any allegation of abuse. Regulation 11 (1)(a) (b)