Requires Improvement

Birmingham and Solihull Mental Health NHS Trust

Services for older people

Quality Report

50 Summer Hill Road
Birmingham
B1 3RB
Tel: 0121 301 2000
Website: www.bsmhft.nhs.uk

Date of inspection visit: 13-15 May 2014
Date of publication: 09/09/2014

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Juniper Centre	RXTD5	Sage, Rosemary and Bergamot wards	B13 8JL
Little Bromwich Centre	RXT 37	CMHT (East), Memory Assessment and Advisory Service, Rare Dementia Team, Community Enablement Recovery team	B10 9JH
Reaside Centre	RX64	Hollyhill Unit	B45 9BE
Ashcroft Unit	RXT06	Ashcroft Ward	B18 5SD

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health Foundation 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 Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health Foundation 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.

Overall rating for Services for older people	Requires Improvement 
Are services for older people safe?	**Requires Improvement** 
Are services for older people caring?	**Good** 
Are services for older people effective?	**Requires Improvement** 
Are services for older people responsive?	**Good** 
Are services for older people 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

We found that the trust needed to make improvements to ensure that everyone who used the service was kept safe. Deprivation of Liberty Safeguard (DoLS) referrals had been made on 14 May. These had not been individualised but had been made as a group, which did not reflect individual needs and circumstances. We noted that the relevant ('Eclipse') forms were completed when a reportable incident occurred. Staff were aware of safeguarding and what to do if they had safeguarding concerns. Where we noted concerns about the safety of care being provided to people, staff had taken action to address these.

We found that the trust needed to make some improvements to make sure that the services delivered were effective. Most of the care plans and assessment records we saw were clear and completed well. They had also been reviewed and updated according to individual needs. People's physical healthcare needs were being assessed and met. However, some health professionals were concerned that additional physical medical healthcare was not always available. The trust had recognised this as a risk and reported that it was being addressed. We were concerned about the lack of dementia awareness training opportunities on some of the wards we visited.

Most of the people who used the service spoke highly of the care and attention shown by staff. This was supported by the relatives and carers that we spoke with. Staff provided people with the encouragement and assistance they needed with eating and drinking. We also saw staff supporting people if they became distressed or uncertain. Staff told us about the support and advice they offered to relatives and carers. We also saw that there were information leaflets and contact numbers available for people and visitors. We found some concerns about privacy and dignity practices on one unit.

The service was responsive. The trust had planned and organised the services to meet the needs of the people it served. People were mostly able to access services quickly, and the admission and discharge arrangements were good. We saw evidence of service specific and trust-wide learning from complaints. We saw some good examples of positive feedback from people and their relatives about how their concerns had been addressed. However, we considered that putting older people with functional mental health needs and older people with organic mental health needs on the same ward may have compromised their quality of care.

The service was well led. Staff told us that they felt supported by their local managers and that they were encouraged to deliver a good service. However, some staff were concerned about the unsettling effect of proposed changes at one unit. We saw that the trust had given staff opportunities to learn about proposed changes and ask questions about them at 'feedback' sessions. Staff spoke positively about the visibility and approachability of the chief executive. Staff were aware of whistleblowing procedures and told us that they would feel confident raising concerns.

Summary of findings

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

Are services safe?

Requires Improvement

We noted that the relevant ('Eclipse') forms were completed when a reportable incident occurred. Staff were aware of safeguarding and what to do if they had safeguarding concerns. They also gave examples of how extra staff are booked in when patients' needs take them away from their core duties. In addition, they told us there were fewer incidents since the new trust procedures had been put in place and reinforced.

The trust had taken steps to improve medicines services for older people. Records showed that medicines were kept at suitable temperatures. We also noted that Deprivation of Liberty Safeguard (DoLS) referrals had been all been made on 14 May. These had not been individualised but had been made as a group, which did not reflect individual needs and circumstances. We saw some good examples of services planning for foreseeable risks. We found good examples of teams being person-centred, with staff working together and referring people onwards. Where we noted concerns about the safety of the care being provided to people, staff had taken action to address these.

Are services effective?

Requires Improvement

Most of the care pans and assessment records we saw were clear and completed well. They had also been reviewed and updated according to individual needs. The records we saw were person-centred and showed that people's families and carers were involved where required. People's physical healthcare needs were being assessed and met. However, some health professionals were concerned that additional physical medical healthcare support was not always available. The trust had recognised this as a risk and reported that it was being addressed.

New staff received both a trust and local induction to the service. The records we saw showed that staff received mandatory and other training. Staff also confirmed that they were supervised on a monthly basis and received and annual appraisals. Senior staff told us that individual care practices were observed as part of supervision. We were concerned about the lack of dementia awareness and other dementia training opportunities on some of the wards we visited.

Are services caring?

Good

Most of the people who used the service spoke highly of the care and attention shown by staff. This was supported by the relatives and carers we spoke with. Staff provided encouragement and

Summary of findings

assistance for people who needed help with eating and drinking. We also saw staff supporting people if they became distressed or uncertain. Staff told us about the support and advice they offered to relatives and other carers. We saw that there were information leaflets and contact numbers available for people who used services and visitors. We identified some concerns about the privacy and dignity practices on one unit.

Are services responsive to people's needs?

Good

The trust had planned and organised their services to meet the needs of the people it served. People were mostly able to access the services quickly and the admission and discharge arrangements were good. We saw evidence of service specific and trust-wide learning from complaints. We also saw some good examples of positive feedback from people and their relatives about how their concerns had been addressed. Staff had access to appropriate specialist services to help them care for people who used the service. However, we considered that putting older people with functional and older people with organic mental health needs on the same ward may have compromised their quality of care.

Are services well-led?

Good

Staff told us that they felt supported by their local managers and that they were encouraged to deliver a good service. However, some staff were concerned about the unsettling effect of proposed changes at one unit. We saw that the trust had given staff opportunities to learn about proposed changes and ask questions about them at 'feedback' sessions. Staff spoke positively about the visibility and approachability of the Chief Executive. Some spoke approvingly of the 'Dear John' system, which allowed staff to email concerns, anonymously if they wished, direct to him.

Senior staff had a good understanding of the strengths of the service and where the areas for improvement were. Staff were aware of whistleblowing procedures and told us that they would feel confident raising concerns.

Summary of findings

Background to the service

Birmingham and Solihull Mental Health Foundation Trust provided services for older people on several inpatient wards and community sites. The inpatient services were located at Ashcroft Unit, Hollyhill, Reservoir Court and Juniper Unit. The community services were based at four sites around Birmingham and Solihull.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett, Consultant Psychiatrist Oxleas NHS trust

Team Leader: Julie Meikle Head of Inspection (Mental Health) Care Quality Commission

The team who inspected these services included a CQC inspector, Mental Health Act commissioners, senior nurse specialists, social workers 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 visited the services for older people between 13 and 15 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, such as nurses, doctors, therapists. We talked with people who use services, their carers and/or family members. We observed how people were being cared for and reviewed their care or treatment records. We also met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider's services say

We saw positive comments from people who used the community mental health services for older people.

These were primarily from a survey of people using this service in March 2014. There were many positive comments on how well the service listened and responded effectively.

Summary of findings

During our visits, we spoke with relatives and patients using the inpatient services. Most of the relatives we spoke with were complimentary about the services. However, some patients with functional mental health problems said that there was a lack of activities. Some felt that this was because of the wide range of patient needs that were catered for, particularly where patients with functional and dementia needs were on the same ward.

Good practice

- We saw good practice in community mental health services for older people. Services were integrated to provide a swift and effective response to people's needs.
- We saw evidence of high standards of person-centred and innovative care practices on Rosemary ward and on the Ashcroft unit.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that all safety equipment checks are carried out to ensure that all the equipment used is in safe working order.
- The trust must ensure that all staff are aware of, and practice safe procedures in supporting people to eat.
- The trust should ensure that expert guidance is sought to review the environment of each unit to make it appropriate for people who are living with dementia.
- The trust should consider making dementia awareness training mandatory for all staff working in older people's services.
- The trust should ensure that all staff receive specific mandatory Mental Capacity Act training so that the rights of people who use this service can be fully protected.
- The trust should consider alternative methods of observing people whilst they are in their bedroom without compromising their privacy and dignity.
- The trust should work with their commissioners to determine whether older people with functional and organic mental health needs should be accommodated on the same ward.
- The trust should ensure that the examples seen of good practice on some units are disseminated throughout the rest of this service.

Birmingham and Solihull Mental Health NHS Trust

Services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CMHT (East), Memory Assessment and Advisory Service, Rare Dementia Team, Community Enablement Recovery team	Community Mental Health Services, Little Bromwich Centre
Sage, Rosemary and Bergamot wards	Juniper Centre
Hollyhill Unit	Reaside Centre
Ashcroft Ward	Ashcroft Unit

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 noted no concerns in respect of the Mental Health Act. There were few detained patients at the locations we visited. There were no errors or omissions noted in the Mental Health Act sections papers. Staff had received mandatory training on this Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

We noted no issues of concern in respect of the Mental Capacity Act or Deprivation of Liberty Safeguards in the community mental health services for older people.

We saw that staff in the in-patient services had received training in the Mental Capacity Act. We found that the applications for Deprivation of Liberty Safeguards for patients had all been made in the week of our visit. We felt that Mental Capacity Act awareness was not yet fully embedded in processes in the trust, with variable evidence of issues of capacity or consent being considered or recorded.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We noted that the relevant ('Eclipse') forms were completed when a reportable incident occurred. Staff were aware of safeguarding and what to do if they had safeguarding concerns. They also gave examples of how extra staff are booked in when patients' needs take them away from their core duties. In addition, they told us there were fewer incidents since the new trust procedures had been put in place and reinforced.

The trust had taken steps to improve medicines services for older people. Records showed that medicines were kept at suitable temperatures. We also noted that Deprivation of Liberty Safeguard (DoLS) referrals had been all been made on 14 May. These had not been individualised but had been made as a group, which did not reflect individual needs and circumstances. We saw some good examples of services planning for foreseeable risks. We found good examples of teams being person-centred, with staff working together and referring people onwards where appropriate. Where we noted concerns about the safety of the care being provided to people, staff had taken action to address these.

Our findings

Juniper Centre

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. We noted the relevant ('Eclipse') forms being completed when a reportable incident occurred. Staff showed a good awareness of when to report incidents and gave us examples of improvements in safe practice in the service.

Learning from incidents and improving safety standards

There had been a serious incident on Bergamot ward the previous year. We saw evidence of a 'learning lessons session' held recently involving staff and external facilitators. This showed that the trust was ensuring that staff were involved in improving practice and minimising the risk of such incidents recurring. The sessions covered complaints received since then and issues raised by them and what lessons could be learnt from them.

Senior staff on both wards were able to clearly articulate what changes and improvements had occurred to practice since the incident. They told us that this involved ensuring that the trust observation policy was adhered to, that staff were clear on roles, that handovers were accurate, timely, and comprehensive, and that a shortage of staff on a shift would not be tolerated.

Staffing boards, informing all visitors what staff were on duty, were clearly and prominently displayed throughout the service.

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

Senior ward based staff told us how specific falls risks were managed and how patients were safeguarded against pressure sore risks. Any pressures sores were closely monitored and any risk managed with individual care plans. The manager told us this approach had been successful and the last grade two pressure sore incident on the ward had been over 12 months ago.

We saw records of a controlled medication audit on Rosemary ward by a pharmacist. This showed us that the trust was working on improving medication services to patients in older people's services. This helped improve patient safety as well as quality of service. We saw records of temperatures being kept showing medications were kept at suitable temperatures. We saw good practice while observing administration of medicines on Bergamot ward.

Assessing and monitoring safety and risk

Managers had told us that high level observations were now accompanied by additional staff. The records seen showed us that the use of trust bank and agency staff had been reduced. Staff felt the gender separation worked well and helped patients feel safer and more secure. We found that the Deprivation of Liberty Safeguard (DoLS) referrals to the local authority had been all been made on 14 May. These had not been individualised but had been made as a group and did not reflect individual needs and circumstances.

Requires improvement

Are services safe?

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

Understanding and management of foreseeable risks

The records seen showed us that environmental risks had been assessed and addressed by the trust. Maintenance requests were responded to fairly promptly. Staff were aware of the trust's emergency contingency policy and procedures. Staff gave us examples of situations where staff had worked flexibly to provide continued care for people. Observation panels ensured people could be observed in their rooms if risk assessments deemed this necessary.

Ashcroft Unit

Track record on safety

We noted the relevant ('Eclipse') forms being completed when a reportable incident occurred. Staff showed a good awareness of when to report incidents and gave examples of improvements in safe practice in the service.

Learning from incidents and improving safety standards

We saw examples of how staff were aware of the risks associated with people who used this service. We saw that the service had learnt from previous incidents. Staff discussed with us a recent example of a safeguarding concern and how it had been managed in accord with agreed procedures. The records seen showed us that the number of incidents and 'near misses' had decreased since new clinical leadership had been appointed to this unit.

We saw that the service had a staffing board in place. This informed people who used services and their visitors of what staff were on duty. This was clearly and prominently displayed. Senior staff gave us examples of how extra staff were booked in when people who used the service required additional support.

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

Staff we spoke with showed a good awareness of safeguarding and what to do if they had safeguarding concerns. The records seen confirmed that staff had attended their mandatory safeguarding training. Senior staff told us how specific clinical risks were assessed and managed. We saw a good example of safeguarding protocols and procedures in place to manage the risks associated with a newly admitted person.

We saw examples of recent safety audits carried out on the unit. This showed the trust was working on improving the safety on this unit. We saw that medications were being securely stored on the unit and the records seen showed us that medications were being kept at suitable temperatures.

Assessing and monitoring safety and risk

We saw staff managing people whose behaviour challenged without recourse to restraint, seclusion or medication. The staffing levels on the unit were safe and we saw that the trust had provided additional staff to enable the enhanced observation of a person who had been risk assessed as requiring more support. Staff told us that there was a supportive staff team on this unit and that this assisted in the collaborative assessment and monitoring of risks within the service.

Understanding and management of foreseeable risks

The records seen showed us that environmental risks had been assessed and addressed by the trust. Maintenance requests were responded to fairly promptly. Staff were aware of the trust's emergency contingency policy and procedures. Staff gave us examples of situations where staff had worked flexibly to provide continued care for people.

Community mental health services

Track record on safety

We noted the relevant ('Eclipse') forms being completed when a reportable incident occurred. Staff showed a good awareness of when to report incidents and gave examples of improvements in safe practice in the service.

Learning from incidents and improving safety standards

We saw examples in community services of how staff were aware of risks associated with people living in the community with dementia and how services responded to those risks. We saw for example, how the service responded to people who had to consider whether they could safely drive. Staff discussed with us a recent example of a safeguarding concern and how it had been managed in accord with agreed procedures.

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

Staff we spoke with showed a good awareness of safeguarding and what to do if they had safeguarding concerns. The records seen confirmed that staff had attended their mandatory safeguarding training. Senior

Requires improvement

Are services safe?

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

staff told us how specific clinical risks were assessed and managed. We saw how assessments and home visits alerted staff to risks which were then responded to in a timely manner.

We accompanied one staff member on a visit where information was obtained that indicated a fire risk. This was then raised with the Community Enablement Recovery Team (CERTS) who arranged for the fire service to contact the person for further support.

Assessing and monitoring safety and risk

Staff told us that there was a supportive staff team on this unit and that this assisted in the collaborative assessment and monitoring of risks within the service. We saw how staff monitored people's physical as well as mental well-being during a visit and took prompt action in involving other professionals regarding health concerns.

We saw a thorough assessment being conducted by a health professional who evaluated and reviewed the information another health professional had gained from face to face contact with a user and carer.

Understanding and management of foreseeable risks

Staff were aware of the trust's emergency contingency policy and procedures. Staff gave us examples of situations where staff had worked flexibly to provide continued care for people.

The service planned for foreseeable risks by having integrated teams that worked together and referred onwards. For example, the memory assessment and advisory service would refer individual case of concern to the Community Mental Health team, who could call in the Rare Dementia service or the Community Enablement Recovery Team as required. The manager and members of staff told us that the services were sufficiently resourced to ensure that the quality of the service was not compromised by lengthy waiting lists. This was confirmed by comments we saw from users of the service.

Hollyhill

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. We noted the relevant ('Eclipse') forms being completed when a reportable incident occurred. Staff showed a good awareness of when to report incidents and gave us examples of improvements in practice in the service.

Learning from incidents and improving safety standards

The manager told us of a serious incident that had occurred three weeks ago. We saw that prompt action had been taken to minimise the chances of a recurrence of such an incident.

Staff also told us they had a debriefing 'away day' session regarding a serious incident on another unit within the service. This was in order to learn from what had happened and minimise the risk of such an event happening at Hollyhill. One of the issues surrounding this incident had been lack of communication and observations not being maintained at the appropriate level. During our visit we saw good communication between staff and good team work to ensure an observation was maintained at the appropriate level.

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

Staff we spoke with showed a good awareness of safeguarding and what to do if they had safeguarding concerns. The records seen confirmed that staff had attended their mandatory safeguarding training.

We saw throughout our visit that members of staff in communal areas were attentive to safety concerns. We saw pressures sore risks were managed effectively. People who remained in bed were repositioned regularly as were people who were seated. The manager was able to tell us the unit did not have anyone suffering from pressure sores. Staff showed a good awareness of pressure area risks and how to minimise them.

Assessing and monitoring safety and risk

Staff were clear on one of the current major risks of one person falling and monitored this person accordingly. We saw staff managing people whose behaviour challenged without recourse to restraint, seclusion or medication.

Senior staff told us that while no-one was currently subject to DoLS (Deprivation of Liberty Safeguards) these had just been applied for the majority of patients in order to comply with legislation as they now realised that people may benefit from this additional safeguard in any restrictions of their liberty.

Requires improvement

Are services safe?

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

Senior staff agreed that mental capacity and Deprivation of Liberty Safeguards were not yet fully embedded into the assessment and treatment processes. This led to the risk of patients' rights and wishes not being fully taken into account in their care and treatment.

Understanding and management of foreseeable risks

We found the suction machine (to be used in emergencies, especially where someone was choking and manual procedures had not alleviated the problem) was not charged. We informed senior staff of this and it was flagged as high risk. We expressed concern that the checks on this machine were not sufficiently robust to ensure it was fully operational.

We observed one person being fed in bed when they were not properly supported to sit upright. There were two pillows behind their head but not behind their back. A staff nurse intervened and ensured they were repositioned to a safer and more comfortable eating position. When we spoke with senior staff they agreed the initial positioning was not appropriate.

The manager told us they would monitor the support given to people being fed by staff in bed, re-emphasise the correct procedures for doing this, and dispel any uncertainty about what was meant by 'sitting up'.

We also observed a patient being given more food when they had an audible 'wet' voice indicating food had 'gone the wrong way'. This was brought to the attention of senior staff who intervened appropriately to promote the safety of the person concerned.

Are services effective?

Requires Improvement

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

Summary of findings

Most of the care pans and assessment records we saw were clear and completed well. They had also been reviewed and updated according to individual needs. The records we saw were person-centred and showed that people's families and carers were involved where required. People's physical healthcare needs were being assessed and met. However, some health professionals were concerned that additional physical medical healthcare support was not always available. The trust had recognised this as a risk and that it was being addressed.

New staff received both a trust and local induction to the service. The records we saw showed that staff received mandatory and other training. Staff also confirmed that they were supervised on a monthly basis and received and annual appraisals. Senior staff told us that individual care practices were observed as part of supervision. We were, however, concerned about the lack of dementia awareness and other dementia training opportunities on some of the wards we visited.

Our findings

Juniper Centre

Assessment and delivery of care and treatment

Staff on Rosemary ward told us there were care plan reviews every week with the multi-disciplinary team and that relatives were invited and given opportunity to ensure they understood what was happening. We spoke with a doctor who explained how people were assessed and regularly reviewed to ensure and maintain their physical well-being. They told us of the similar process involved in discharging people to other services.

Staff on Rosemary said they had good access to health professionals when needed. However, some health professionals had expressed concerns that additional physical medical healthcare support was not available at all times. We were told by senior staff that this had been recognised as a risk by the trust and that it was being addressed.

We reviewed the treatment records on Bergamot ward and saw that each person had assessments and care plans within two weeks of admission.

Outcomes for people using services

Senior staff old us the average length of stay was 90 days. The longest stay had been one year. They said stays over 90 days are queried and that the 'ideal' stay is 45 days. They confirmed that delays are most often are caused by need to find a suitable placement. It was reported that 50% of people returned home with support packages, and approximately 50% went to a long term care setting. Some people who needed additional support or assessment went on to one of the complex care units at Ashcroft or Hollyhill.

Staff, equipment and facilities

We noted that new staff had received both a trust and local induction to the service. The records seen demonstrated that staff received mandatory and other training. We reviewed the training records and these showed us that some, but not all, health care assistants had received dementia awareness training. This meant that there were gaps in the provision of dementia training for front line staff.

The wards were generally clean and maintenance requests had been addressed. There was sufficient equipment seen to meet the specific care needs of the people who used this service.

Multidisciplinary working

Senior staff reported good multi-disciplinary working. Good examples were seen of working with other health care providers. For example when people were being assessed for admission or transfer to this service. Care plans were in place to meet the needs of people with complex and challenging needs.

Evidence was seen of pro-active discharge planning with local social services and private providers of nursing homes. One patient from Rosemary ward was currently receiving treatment at the local acute NHS trust. The manager told us one staff member on each shift was currently assigned to be there to support them. This was good practice, enabling patient to be effectively supported in another environment.

Are services effective?

Requires Improvement

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

Mental Health Act (MHA)

We noted compliance with the Mental Health Act where there were patients who were detained, with the records reviewed being compliant with the required legislative requirements.

Ashcroft

Assessment and delivery of care and treatment

The care pans and assessment records seen were clear and well completed. We saw evidence that these had been reviewed and updated according to individual need. Those records seen were person centred and demonstrated the involvement of families and carers where required.

We noted that people were having their physical health care needs assessed and met. We met a visiting General Practitioner who explained their role in supporting the unit.

We saw that people were being assisted to eat and drink and had their choice of snacks and drink respected. Staff explained how they cared for people who were at risk of developing pressure areas.

Outcomes for people using services

Staff told us how they monitored the outcomes for people. For example at weekly multi-disciplinary reviews and by the use of audits and other outcome assessments and measures. We saw that the unit had nominated staff members as staff "leads" for specific areas such as privacy and dignity and nutrition.

Staff, equipment and facilities

We noted that new staff had received both a trust and local induction to the service. The records seen demonstrated that staff received mandatory and other training. Staff confirmed that they received monthly supervision and annual appraisals. Senior staff told us that individual care practices would be observed as part of supervision.

Staff confirmed that they were enough staff on duty to meet the needs of the people who used the service. Further staff were on duty to meet the assessed needs of a newly admitted person.

The ward environment was clean. We saw that people were cared for in gender specific corridors. A number of person centred activities including gardening and music were taking place.

Multidisciplinary working

Senior staff reported good multi-disciplinary working but expressed some concerns about out of hours medical cover from the trust's on call psychiatrists. This was mainly due to the 'stand-alone' aspect of this service.

Good examples were seen of working with other health care providers. For example when people were being assessed for admission or transfer to this service. Clear care plans were in place to meet the needs of people with complex and challenging needs.

Evidence was seen of pro-active discharge planning with local social services and private providers of nursing homes.

Mental Health Act (MHA)

Staff confirmed they had received training on both the Mental Health Act and the Mental Capacity Act. We noted compliance with the Mental Health Act where there were patients who were detained, with the records reviewed being compliant with the required legislative requirements.

Community mental health services

Assessment and delivery of care and treatment

The care pans and assessment records seen were clear and well completed. We saw evidence that these had been reviewed and updated according to individual need. Those records seen were person centred and demonstrated the involvement of families and carers where required.

We saw examples of support being delivered and arranged effectively. Staff we spoke with were clear on guidelines and parameters in which they worked. We saw how the memory assessment service had taken action to ensure referrals to it were appropriate.

The service had a clear focus on enabling people to have the right care and treatment so they could maintain independence and giving support and advice to carers so that could continue to provide care to the person. We noted many positive comments on a recent survey from users and their carers/relatives that illustrated the effectiveness of this service.

Outcomes for people using services

Staff told us how they monitored the outcomes for people. For example by the use of audits and other outcome assessments and measures. Staff consistently told us that good outcomes for people they supported were for them to continue to live independently.

Are services effective?

Requires Improvement

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

Staff, equipment and facilities

Staff showed a good knowledge of dementia care and of older people's mental health needs. Discussions with staff and observations of them with clients and showed us that they had a good awareness of individual needs and of the help that people needed. This was apparent in comments from users of the service who spoke about the expert advice, listening skills and support provided by all the community services for older people.

Staff told us training was effective, with mandatory training ensuring all main areas were covered, with staff supported to do additional relevant learning.

Staff told us they received regular clinical and management supervision and that everyone in the team was supportive of each other. This was supported in observations of staff discussions and meetings. Staff told us that they were comfortable supporting each other's roles as the need arose.

Multidisciplinary working

We saw effective multi-disciplinary working between the local community mental health team and the city wide services they shared premises with. We saw these teams working together well and also linking effectively with other services. Comments by people who used these services showed a broad satisfaction with the way teams worked together.

Mental Health Act (MHA)

Staff understood their role in supporting people within the community and how and when they would call on relevant professional support if required under the Mental Health Act.

Hollyhill

Assessment and delivery of care and treatment

The care pans and assessment records seen were clear and well completed. We saw evidence that these had been reviewed and updated according to individual need. Those records seen were person centred and demonstrated the involvement of families and carers where required. However, the majority of people were unable to give their informed consent regarding their admission and treatment. There was a lack of clear assessments regarding patients' ability to consent to treatment.

We saw examples of support being delivered and arranged effectively. We noted a number of factors indicating good care and treatment. Senior staff told us there were no pressure sores amongst people who used the service, with procedures in place to monitor and take effective action to prevent these occurring.

Outcomes for people using services

The service had become designated as a complex care unit in September 2013, managing behaviours that may challenge and could not be managed elsewhere in the trust. The manager told us that the average stay was 18 months, with the longest stay currently being three years. The aim was to assess, treat and move people to suitable placements elsewhere. Staff told us the mix of patients with organic and functional mental health problems sometimes caused difficulties in meeting different needs. They confirmed that delays in discharging people were most often caused by the need to find a suitable placement.

Staff, equipment and facilities

We spoke with nurses and found them to have a good understanding of the needs of patients. Nurses told us they did not have specific dementia training but relied on self-directed study.

Senior staff told us the trust has a 'traffic light' training policy whereby all mandatory training needs are highlighted and are required to be acted upon. They said this only applied to training that was mandatory across the trust. They said there was no system that made particular training, such as dementia awareness, mandatory in specific settings where it was highly relevant. Consequently many staff did not undertake such training.

Staff told us that although most people had dementia related needs, a significant number had functional mental health needs. We were told these made up approximately 30% of the ward group. Staff felt that it might be easier to make the ward more dementia friendly if the service was purely or at least predominantly cared for people living with dementia.

Whilst the service was clean and maintenance requests addressed. We found that people's bedrooms that we saw showed little evidence of being personalised to reflect the personality or preferences of the person, although they were likely to be there for a year or more.

Multidisciplinary working

The unit had support from other professionals, such as occupational therapists and physiotherapists. Clinical and medical support was available but this was time limited

Are services effective?

Requires Improvement

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

and staff told us they felt they could benefit from more medical support being available. We found an example of a person with nutritional issues. Additional support had been provided by the trust to assist staff to meet their specific needs.

Mental Health Act (MHA)

Two patients were detained under the Mental Health Act. There were no concerns noted regarding the detention of these two patients. The other 22 patients were there on an informal basis. Discussion with staff and a sampling of patient records showed that mental capacity was not fully embedded in assessment processes. We found that recording of capacity issues appeared variable and inconsistent across those records reviewed.

Good

Are services caring?

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

Summary of findings

Most of the people who used the service spoke highly of the care and attention shown by staff. This was supported by the relatives and carers we spoke with. Staff provided encouragement and assistance for people who needed help with eating and drinking. We also saw staff supporting people if they became distressed or uncertain. Staff told us about the support and advice they offered to relatives and other carers. We saw that there were information leaflets and contact numbers available for people who used services and visitors. We did, however, identify some concerns about the privacy and dignity practices on one unit. We raised these with senior staff during our inspection.

Our findings

Juniper Centre

Kindness, dignity and respect

We saw that the people who used this service were treated with kindness and respect. Respect and dignity was generally supported by the environment. Doors have observation panels so people could be observed when needed with minimal effect on their privacy and dignity. En-suite lights could alert others when a person was using this facility.

We saw that patients had choices at meal time with culturally appropriate choices available. We noted one lady on Rosemary Ward who had now got special cutlery and was now able to eat more independently.

Most of the people who used the service spoke highly of the care and attention shown by staff. This was supported by the relatives and carers we spoke with. Staff provided encouragement and assistance for people who needed help with eating and drinking. We also saw staff supporting people if they became distressed or uncertain. Staff told us about the support and advice they offered to relatives and other carers.

Examples were seen of activity provision throughout the service. Most people appeared to be enjoying these supported by staff.

People using services involvement

We saw staff actively involving people in their care for example seeking permission before providing assistance. Good examples were seen of the active involvement of carers and relatives where appropriate.

We noted on Rosemary ward that there were specific visiting times. Staff advised us these could be made flexible for valid reasons and they were aware relatives often had to link visits with bus times and similar considerations.

We saw a staffing board outside Rosemary ward clearly identifying staff that were on duty as an aid to patients and visitors. Knowing what staff were on duty helped people who used services and visitors be clearer on whom they may wish to speak with on any matters of concern.

Emotional support for care and treatment

We saw staff supporting people if they became distressed or uncertain. Staff told us of support and advice offered to relatives. We saw information leaflets and contact numbers available for relatives and other carers.

Ashcroft Unit

Kindness, dignity and respect

We noted some good examples of innovative and person centred care on this unit. Staff were seen to be treating people with respect and kindness. People who used the service spoke highly of the care and attention shown by staff. This was supported by those visiting relatives and carers that we spoke with. People were supported to choose what they would like to drink and eat. Encouragement and where needed assistance was being provided by staff to people who needed help with eating and drinking.

We saw that privacy and dignity was being maintained by staff. For example when attending to a person who required assistance with their continence.

People using services involvement

We saw staff actively involving people in their care for example seeking permission before providing assistance. Good examples were seen of the active involvement of carers and relatives where appropriate. This was supported by those visitors spoken with during the inspection and the formal feedback seen on the unit. This included ‘thank you ‘letters and cards.

Good

Are services caring?

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

Emotional support for care and treatment

We saw good examples of emotional support being provided to the people who used this service and their carers. For example in those care and treatment records reviewed and as described by those visitors that we spoke with. There was a good provision of information leaflets and use of noticeboards to provide condition specific information for people and visitors. For example we saw information on skin integrity and nutrition.

Community mental health services

Kindness, dignity and respect

Discussions with staff, observations of discussions and practice and comments from people using the service showed us that the service treated people with respect and upheld their dignity. Feedback comments from users of the service had many positive comments about the fact that staff listened to them and responded appropriately. "Understanding," listening" and "sensitive" were terms frequently used.

Staff working for the service showed a good understanding of differing needs, cultures and background. They were able to take these into account and tailored responses and services accordingly.

People using services involvement

The service involved people fully in their treatment and care. One survey comment noted "Really appreciate that doctors talk to both of us. We would find it disrespectful if doctor addressed the relative only." We saw a service user database had been developed to involve service users in the recruitment process for staff vacancies.

Emotional support for care and treatment

Discussions with staff, observations of staff and feedback from service users and their relatives showed that people are supported in ways that reflected their individual circumstances and needs. Comments from the service user survey noted that staff listened, were sensitive to needs and gave people time, as well as the support to maintain their independence.

Hollyhill Unit

Kindness, dignity and respect

We saw staff working extremely hard to meet people's needs and managing challenging behaviours in a calm and patient manner.

We saw people being responded to in ways that helped maintain their dignity and wellbeing. We saw medication being dispensed in a calm and friendly manner, with nurses using their skills and knowledge of individuals to encourage them to accept prescribed medication.

We did not see people being distressed without staff promptly offering reassurance and comfort. One relative we spoke with compared the unit very favourably with a previous experience. They told us; "There are more nurses here, staff are more caring here, it is cleaner."

One person told us; "The people are very good here, I get on well with all the nurses and the patients. They are all very nice people."

A number of people were in bed during our visit. Doors had no observation panels, so these patients were clearly visible to people passing by in the main corridor. Staff told us their doors were kept ajar for safety and observation purposes, but acknowledged that the patients concerned were unlikely to have been able to give informed consent for their privacy and dignity to be compromised in this way.

We saw that staff respected the privacy and dignity of people whilst they were being assisted with personal care. This was done in a discreet and private manner with doors closed.

People using services involvement

We saw staff actively involving people in their care for example seeking permission before providing assistance. Good examples were seen of the active involvement of carers and relatives where appropriate.

Emotional support for care and treatment

We saw staff offering support to people and reassuring them. Most staff had worked at the unit for a number of years and were familiar to patients and appeared to be liked and trusted by them. Relatives were made welcome and spiritual needs were catered for by the presence of a chaplain.

Are services responsive to people's needs?

Good

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

Summary of findings

The trust had planned and organised their services to meet the needs of the people it served. People were mostly able to access the services quickly and the admission and discharge arrangements were good. We saw evidence of service specific and trust-wide learning from complaints. We also saw some good examples of positive feedback from people and their relatives. Staff had access to appropriate specialist services to help them care for people who used the service. However, we thought that putting older people with functional and older people with organic mental health needs on the same ward may have compromised their quality of care. We brought this to the attention of senior staff at the trust.

Our findings

Juniper Centre

Planning and delivering services

This service was planned to support people who need assessment and support in order to either return to their care setting or to identify what additional support was required for them. Whilst there were systems in place for effective discharge planning. We found that there were sometimes difficulties in finding suitable placements for people.

Right care at the right time

The records seen showed us that people's needs were fully assessed upon admission to the service. We saw that comprehensive assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of clear admission assessments and discharge procedures.

We saw staff being responsive to patient needs. We did not witness any patients calling for assistance and not receiving it promptly.

We saw that staff were extremely busy, but organised themselves and were deployed effectively in order to meet patient needs in a timely manner. Trust staff ensured that where a patient, for example, was in hospital, a member of staff was put on the rota to ensure that person was supported properly.

Care pathway

We saw that timely assessments of people's needs took place following their admission so that individual needs and wishes were understood. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of clear admission assessments and discharge procedures.

Learning from concerns and complaints

We saw evidence of unit based learning sessions which looked at complaints received, and issues raised by them and what lessons could be learnt from them. These were attended by a wide variety of staff and showed the trust were responding to complaints and endeavouring to learn and improve practice in response to such complaints. Senior staff confirmed that any informal concerns were addressed promptly.

Ashcroft Unit

Planning and delivering services

The service was planned to assess and care for people with complex needs with the aim of identifying possible future placements or to return home with additional support as required. We saw that staff had access to appropriate specialist services. For example advanced palliative care practitioners were supporting staff with some people who used the service.

Right care at the right time

The records seen showed us that people's needs were fully assessed upon admission to the service. We saw staff being responsive to people's needs. We did not witness any incidents of people calling for assistance and not receiving it promptly. We saw that staff were busy, but had time for people and their visitors. Senior staff ensured that additional staff were on duty to provide enhanced support for people who required this.

Care pathway

We saw that comprehensive assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the

Are services responsive to people's needs?

Good

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

people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of clear admission assessments and discharge procedures.

Learning from concerns and complaints

Staff told us they had not received any formal complaints from people who used this service in the past year. The most recent trust survey showed people were satisfied with the service. Senior staff confirmed that any informal concerns were addressed promptly and this was confirmed by those visitors that we spoke with and the care and treatment records reviewed.

Community mental health services

Planning and delivering services

The community mental health services served geographic parts of the city. Specialist older peoples' services were a city wide service. These teams all worked together to provide a comprehensive service for people with different mental health needs.

Right care at the right time

We noted there was an effective approach to managing referrals and assessments and there were plans in place to tackle any identified problems. For example, we noted that flexible treatment appointments being offered to people.

Care pathway

Those care and treatment records reviewed showed us that the service took into account people's needs and wishes when care and treatment was being planned and delivered.

Discussion with staff, observations and user feedback showed that people's diverse cultural needs were taken into account. Translators and other support was able to be accessed as required.

We spent time in the Rare Dementia team allocation meeting and saw how staff worked together and referred for additional support as necessary in order to ensure vulnerable people's needs were fully assessed and managed to enable people to continue to be as independent as possible without jeopardising their safety. We saw how the flexible and adapted to meet people's changing needs.

Learning from concerns and complaints

Staff told us they had not received any complaints from users in the past year. The most recent survey showed people were very satisfied with the service, with a few minor issues being in the context of overall satisfaction.

The service had however noted where people could no longer be supported to live independently and residential placements had to be made, placements were not always appropriate and had to be further supported. The service had initiated a care home liaison service to address this with the aim of minimising inappropriate care home placements, particularly for those with rare or complex forms of dementia. This scheme had only just started so it was too early to judge its success.

Staff at the memory assessment clinic told us that initially they were receiving too many inappropriate referrals from GPs. This had been responded to with guidelines on appropriate and inappropriate referrals.

Hollyhill Unit

Planning and delivering services

The service was planned to assess and care for people with complex needs with the aim of identifying possible future placements or to return home with additional support as required. We considered that having older people with functional and organic mental health needs on the same ward may have compromised the quality of care of both groups of people.

Whilst there were systems in place for effective discharge planning. We found that there were sometimes difficulties in finding suitable placements for people.

Right care at the right time

We saw that comprehensive assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of clear admission assessments and discharge procedures.

Care pathway

Those care and treatment records reviewed showed us that the service took into account people's needs and wishes when care and treatment was being planned and delivered.

Are services responsive to people's needs?

Good

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

We spoke with chaplain lead who told us spiritual matters are catered for and that they were told when people were on end of life care.

Learning from concerns and complaints

We spoke with a relative who had complained about elements of the service. The manager was able to show us how the complaint and been responded to and how it improved practice. Senior staff confirmed that any informal concerns were addressed promptly.

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

Staff told us that they felt supported by their local managers and that they were encouraged to deliver a good service. However, some staff were concerned about the unsettling effect of proposed changes at one unit. We saw that the trust had given staff opportunities to learn about proposed changes and ask questions about them at 'feedback' sessions. Staff spoke positively about the visibility and approachability of the chief executive. Some spoke approvingly of the 'Dear John' system, which allowed staff to email concerns, anonymously if they wished, direct to him.

Senior staff had a good understanding of the strengths of the service and where the areas for improvement were. This enabled them to focus on the areas that needed improvement. Staff were aware of whistleblowing procedures and told us that they would feel confident raising concerns.

Our findings

Juniper Centre

Vision and strategy

We saw that staff on this unit were aware of the trust's vision and strategy. Staff were kept aware of this and other developments within the trust at regular staff meetings and via the trust's intranet site.

Wards on this unit were in the process of undergoing structural change. Some staff were concerned about the unsettling effect of it but others were more relaxed. We saw that the trust had given staff opportunities to learn about the proposed changes and ask questions about them at 'feedback' sessions.

Responsible governance

There was a local governance structure in place and staff were aware of their role in monitoring concerns and reporting these to their line manager. Staff aware of their responsibilities and the staff we spoke with had an understanding of trust leads to contact for information if necessary regarding safeguarding and specific areas around use of the Mental Health Act (1983) and the Mental Capacity Act (2005). There was a local risk register in place, which ensured that issues raised were addressed. We saw that actions had been taken from the concerns identified by the risk register.

We saw that the service had organised 'feedback sessions' to discuss and learn from incidents and to involve staff fully in this learning and changes.

Leadership and culture

Senior staff told us they felt well supported and managed with formal and clinical supervision. They said they got support whenever needed and were "never left out on a limb." They acknowledged they were changes in the way the service was run and that these could be unsettling for staff but felt that they and their staff were reasonably confident about change.

Staff told us of regular visits by the executive team and that they had regular supervision and appraisals and felt supported by management.

Whatever concerns they had, staff spoke positively about the visibility and approachability of the Chief Executive. Some spoke approvingly of the 'Dear John' system, which allowed staff to email concerns, anonymously if they wished, direct to him.

Engagement

We saw helpful and clear information leaflets available for relatives and other visitors. The manager and staff were accessible to patients and visitors. There was information available about how to provide feedback on the unit. Staff told us that they were aware of the trust's whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

Performance improvement

We saw an audit of missed medications for this service and action taken to address the findings. This showed us that the trust were working on improving medication services to patients in older people's services. 'Feedback sessions' involving staff in discussing incidents and complaints ensured that action was being taken to improve the service provided.

Staff received annual appraisals and regular supervision. Their line manager ensured that any identified concerns were managed and monitored so that the performance of the unit could be tracked and improved.

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.

Ashcroft Unit

Vision and strategy

We saw that staff on this unit were aware of the trust's vision and strategy. Staff were kept aware of this and other developments within the trust at regular staff meetings and via the trust's intranet site.

Responsible governance

There was a local governance structure in place and staff were aware of their role in monitoring concerns and reporting these to their line manager. Staff aware of their responsibilities and the staff we spoke with had an understanding of trust leads to contact for information if necessary regarding safeguarding and specific areas around use of the Mental Health Act (1983) and the Mental Capacity Act (2005). There was a local risk register in place, which ensured that issues raised were addressed. We saw that actions had been taken from the concerns identified by the risk register.

Leadership and culture

Staff spoke highly of their local managers and were aware of the trust's quality initiatives such as 'Dear John' and 'learning into action'. However they reported that they had not been visited by trust executives recently.

Engagement

We saw helpful and clear information leaflets available for relatives and other visitors. The manger and staff were accessible to patients and visitors. There was information available about how to provide feedback on the unit. Staff told us that they were aware of the trust's whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

Performance improvement

Staff received annual appraisals and regular supervision which gave them the opportunity to identify areas of individual growth and development. Senior staff ensured that any identified concerns were managed and monitored so that the performance of the unit could be tracked and improved.

Community mental health services

Vision and strategy

We noted that staff on this were aware of the trust's wider vision and strategy. Staff were kept aware of this and other developments within the trust at regular staff meetings and via the trust's intranet site.

We spoke with staff who worked in the Memory Assessment and Advisory Service. They were clear about their roles and of the place and function of the service within the wider framework of trust services.

Responsible governance

There was a local governance structure in place and staff were aware of their role and responsibilies in monitoring concerns and reporting these to their line manager.

The managers attended monthly integrated governance meetings and monthly community forum meetings. They informed us they cascaded information to their teams via supervision and team meetings. Staff said they felt valued and listened to and had a good working relationship with their line managers.

We noted there was a local risk register in place which identified specific risks. The training records reviewed showed us that mandatory training was up to date.

Leadership and culture

Staff told us they were well-supported by their local manager and they felt they could work well with senior management. Staff told us that the executive board visited these services regularly

Staff consistently told us they were proud of the work they did. They told us they were "kept informed of any changes" and that "the board was very visible."

Engagement

We saw evidence of regular engagement with people to get their views. The results of the most recent user survey, from two months ago, were overwhelmingly positive. We saw evidence of the service supporting and facilitating local user groups such as Carers Events and Dementia Council and of a recent award for engagement work with users. Staff were aware of the trust's whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

Performance improvement

We saw evidence of the service seeking accreditation with relevant bodies as part of improving quality.

Staff in, for example, the Memory Assessment and Advisory Service had a good understanding of what expected throughputs would be, with percentages of patients seen being referred to other services and agencies.

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.

Staff received annual appraisals and regular supervision which gave them the opportunity to identify areas of individual growth and development. We were given two examples of concerns over individual practice and how these had been identified and appropriately managed.

Hollyhill Unit

Vision and strategy

Staff we spoke with said they were aware of the trust's vision and values and strategic objectives. We found evidence of this strategy and vision on display within the service. Staff confirmed that they received regular trust updates via the trust's intranet and other bulletins and trust updates.

Responsible governance

There was a local governance structure in place and staff were aware of their role and responsibilities in monitoring concerns and reporting these to their line manager. Staff said they felt valued and listened to and had a good working relationship with their line managers.

We noted there was a local risk register in place which identified specific risks. The training records reviewed showed us that mandatory training was up to date.

Leadership and culture

Nursing staff we spoke with told us they had good access to regular supervision and good support from other professionals. Some staff had told us they would be happier with more on-site consultant support.

Staff spoke highly of their local managers and were aware of the trust's quality initiatives such as 'Dear John' and 'learning into action'.

Engagement

We saw helpful and clear information leaflets available for relatives and other visitors. The manger and staff were accessible to patients and visitors. Staff were aware of the trust's whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

Performance improvement

Staff received annual appraisals and regular supervision which gave them the opportunity to identify areas of individual growth and development. Senior staff ensured that any identified concerns were managed and monitored so that unit performance could be tracked and improved.

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 on the Hollyhill unit 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 protect people on the Hollyhill unit who may be at risk from the use of unsafe equipment by ensuring that the equipment provided is properly maintained and suitable for its purpose. Regulation 16 (1) (a)