

# St Andrew's Healthcare

## Quality Report

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Core services inspected	CQC registered location	CQC location ID
Long stay/forensic/secure services	St Andrew's Healthcare - Mens Service	
	St Andrew's Healthcare - Womens Service	1-121538205
	St Andrew's Healthcare - Birmingham	1-121538225
	St Andrew's Healthcare - Essex	1-121538294
	St Andrew's Healthcare - Nottinghamshire	1-121538312
	St Andrew's Healthcare - Nottinghamshire	1-233736027
Child and adolescent mental health services	St Andrew's Healthcare - Adolescents Service	1-121538276
Services for older people	St Andrew's Healthcare - Neuropsychiatry Service	1-121538260
Inpatient services for people with learning disabilities or autism	St Andrew's Healthcare - Mens Service	1-121538205
	St Andrew's Healthcare - Womens Service	1-121538225
PICU place of safety	St Andrew's Healthcare - Essex	1-121538312
Acute admission wards	St Andrew's Healthcare - Mens Service	1-121538205
	St Andrew's Healthcare - Essex	1-121538312

This report describes our judgement of the quality of care at this provider. It 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.

# 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 mental health services at this provider

Requires Improvement



Are mental health services safe?

Requires Improvement



Are mental health services effective?

Good



Are mental health services caring?

Good



Are mental health services responsive?

Good



Are mental health services well-led?

Requires Improvement



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

### **We rated St Andrew's Healthcare overall as requiring improvement because we identified concerns in both the safe and well-led domains.**

We rated the safe domain as requires improvement because we found the following:

- Environmental concerns including, actions from ligature audits were not completed in the Essex location. There were blind spots in some seclusion rooms and bedrooms.
- Medicines in the Birmingham hospital were not stored and disposed of safely.
- Care and treatment records were incomplete.
- Staffing Concerns including, a high use of bureau (bank and agency) staff. Night time cover on wards was a concern as staff were frequently moved from allocated wards to address shortfalls. There was only one doctor providing waking cover with a second doctor on call to the Northampton site between 11pm and 8am.
- We had concerns with the assessing and management of risk. We were concerned with the number of prone restraints being used in the CAMHS wards. Risk assessments and care plans around the use of prone restraint were not always in place.
- We also identified concerns with seclusion practices including poor recording and reviewing. We also saw that seclusion rooms were used for "time out".

We rated the well-led domain as requires improvement because we found the following:

- The governance systems were not effective as there were variations in quality of service between hospital locations and between services in the same hospital or core service area. Even though we found that the board assurance framework and charity wide risk register, had identified many of the risks during our inspection.
- In some services staff morale was low. Staff working on the CAMHS wards told us they felt underappreciated by those senior managers and often felt not listened to as the provider was focused on other services areas. Staff from the learning disability wards told us they found it difficult working with high numbers of bank and agency staff in challenging environments.

- Some managers were managing more than one service. This was affecting their availability and effectiveness.

In the core services inspected we saw evidence of good practice. This was being delivered by caring and professional staff who were working collaboratively. However this was not the case in the learning disability service or the child and adolescent learning disability wards. Where we found that;

- Information was not produced in an accessible format for people.
- The staff we spoke with did not have a good knowledge of the safeguarding policy or procedures.
- There were issues with the use of and recording of seclusion. This included using seclusion facilities for "time out".
- Notifications of incidents that required reporting to the CQC had not been made.
- There was a high use of bureau (bank and agency) staff which meant that staff did not always know the patients. The handovers that we observed were not comprehensive.
- We saw the use of a generic, restrictive risk safety system rather than individual risk assessments based on patient needs. These plans were often not discussed with or explained to the patient in a way that they understand. We were concerned that not all care and treatment was patient centred and relevant to the patient group.
- Managers and staff had a very limited understanding of children's rights in the CAMHS services which meant care was not always planned in accordance with children's rights.

The board, executive team and senior managers had recently undergone changes in key roles including a new chairman, chief executive and chief finance officer. People who use the services, staff and external stakeholders told us of new initiatives and plans to develop the service.

Before and during our inspection, people told us that most staff treated them with kindness, dignity and respect.

# Summary of findings

The provider managed risks and identified and investigated safeguarding concerns. Staff were aware of their role to identify and report all concerns and risks. However in the Essex service actions identified in the ligature risk assessment had not been completed on Audley ward. Care and treatment records were incomplete for one patient who had long term physical healthcare needs.

We visited all of the wards where detained patients were being treated. In the majority of the care records, which related to the detention, care and treatment of detained patients, the Mental Health Act (MHA) and the code of practice had been followed.

The provider was providing evidence based treatments in line with best practice guidance. Patients were being supported to make choices and gave informed consent where possible.

The provider was using outcome measures to judge the effectiveness of the treatment provided.

The governance processes were not fully supported by robust quality assurance systems. Many of these systems were new and had not always identified poorly performing services in a timely manner. This meant that although the provider understood its broad areas of risk it did not always identify all of the areas of concern early enough.

St Andrew's Healthcare was providing a caring service for people across all locations. We saw throughout the inspection staff treating people with kindness, dignity and compassion. The feedback received from people who used services and their visitors was generally positive about their experiences of the care and treatment provided by the provider. However there were

concerns identified on the learning disability wards. We were told that patients' and carers' were not involved in the planning of care. The care plans were not being produced in a person centred way and these were not available in an accessible format to assist patients to understand them.

Staff worked well together to meet people's needs and that they were able to respond to individual needs and preferences.

The provider was in a period of change. The governance system for executives and non-executives was changing from a charity to a health provider and people were being appointed with health experience to effectively offer challenge. Lines of communication from the board and senior managers to frontline services were seen as a priority and people told us that the new chief executive had more presence in the clinical areas. Staff felt well supported by their immediate line managers. However the organisations vision and values were not fully embedded across the provider.

The main challenge for the provider was to ensure that governance processes were supported by quality assurance systems. This has meant that in each domain there are areas of very positive work but also areas where improvements are required.

There were variations in the quality of service provided between locations and services in the same locations or core service area. As a consequence there are a number of compliance actions relating to different services and it is our view that the provider needs to take steps to improve the quality and safety of their services. We will be working with them to agree an action plan to help improve the standards of care and treatment.

# Summary of findings

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

We always ask the following five questions of the services.

### Are services safe?

Requires Improvement



#### We rated safe as requires improvement because:

- There were concerns identified in some of the older buildings and services were operating on the understanding that there would be significant improvement to these environments. The older buildings were either being upgraded or there were plans to re-provide these service in new builds.
- In Essex, on Audley ward actions from ligature audits had not been taken. On Maldon ward care and treatment records were incomplete in respect of one patient's enduring physical healthcare needs.
- In Nottingham, there were blind spots in all seclusion rooms and some bedrooms.
- In Birmingham, medicine in the pharmacy was not stored and disposed of safely. There was not a way to ensure that food was safely stored. The seclusion room in Northfield was not safe at the time of our inspection. The provider took immediate steps to make this room safe during the inspection.
- The provider was maintaining safe staffing levels in inpatient services with the use of bureau (bank and agency) staff. The provider tried to ensure that bureau (agency and bank nurses) used were familiar with the ward and knew the people who used services. However this was not always possible and some patients told us that this meant that they did not feel safe or were not able to take leave.
- At night, ward nursing cover was a concern as regular staff were frequently moved between wards to ensure that other wards had enough staff.
- The medication was managed in adherence to professional guidance. However concerns were raised about the storage and disposal of medication at the Birmingham hospital
- There was limited medical cover at night. One doctor providing waking cover with a second doctor on call to the Northampton site between 11pm and 8am.
- In the children and adolescents mental health service people were being restrained in the prone (face-down) position to manage disturbed behaviour. We also found that risk assessments and care plans for prone restraint were not always in place.

# Summary of findings

- There were concerns around the use of seclusion, these included reviews not being consistently documented after patients had been secluded and staff not following the seclusion policy. The seclusion room on some wards was also being used for “time out” in contradiction to St Andrew’s seclusion policy.
- Some staff did not know the safeguarding process or where they could find out about current ward issues.
- There was an incident folder available on all wards, staff who had not attended meetings had sight of this and were asked to sign when read. However this was not consistently applied across all wards.
- The CQC had not been sent required notifications relating to incidents affecting the service or the people who use it within the learning disability service.

## Are services effective?

Good



### We rated effective as good because:

- Care for individuals was planned by effective multi-disciplinary working (MDT). People using the service were supported and encouraged to make choices about their care.
- In the older adult services care plans were detailed, personalised and described the care we observed being provided.
- Care plans relating to physical health included liaison with the onsite GP services.
- There was good use of the “my shared pathway” tool which embedded patient involvement and were written from the patient point of view.
- The provider was providing evidence based treatments in line with best practice guidance. The provider assessed outcomes for people using of the Health of the Nation Outcome Scales (HoNOS) secure assessment tool.
- Audits were being undertaken including infection control, medication records and clinic room equipment.
- Staff received regular supervision. In some areas there was an addition reflective practice session facilitated by the psychologist.
- Appraisal of performance was undertaken annually.
- The hospital had access to GP services, a practice nurse, an advanced nurse practitioner, as well as podiatry and dentistry services.

# Summary of findings

- The provider delivered and monitored a programme of ‘mandatory’ training for their permanent and bureau staff. 90% or more of the staff had completed this training.
- The Mental Health Act paperwork for patients’ was accurate and complete in all sections. However some informal patients were asked to sign a contract for granted leave, which does not reflect the Mental Health Act.
- People who were detained had access to an independent mental health advocacy services.
- Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). We saw that, where required, capacity assessments had been completed and reviewed and were related to specific issues.

## Are services caring?

Good



### We rated caring as good because:

- Most people told us that staff were approachable and they gave them appropriate care and support. This was supported by the care interactions that we observed.
- During our visit, we witnessed several occasions where staff responded to a patient in distress. They did this discreetly and protected the dignity of the individual.
- Patients we spoke with told us they were happy and staff were great, kind and caring towards them.
- The provider had systems to encourage people to be involved in their assessment, care planning and reviews through use of recovery tools such as ‘my shared pathway’.
- People had the opportunity to attend a hospital based ‘service user forum’, ward based community meeting.
- Staff included the views of patients’ in care plans and also included the views of relatives where appropriate. Notes from multi-disciplinary meetings showed that relative and patients had been involved.
- There were some barriers to active involvement for friends and families due to the distance that some people were away from their families.
- On admission, a patient received an information pack about the ward which included pictures to assist them to understand the content.
- Independent advocacy services were available to all patients.
- We saw patients’ views were included in care plans and this included relatives views where appropriate. However we found the following exceptions:



# Summary of findings

- In the male forensic service, patients' views were not consistently documented in clinical records.
- In the learning disability service, there was little evidence that patients or their carers were actively involved in writing or reviewing care plans. Most patients did not have a copy of their care plan or knew what their goals were. Those who did have care plans did not have these in an accessible format.
- In the learning disability services at Northampton we observed little activity or interaction between staff and patients on the wards we visited. Some patients felt angry and frustrated by how they are treated, stating that staff did not listen to them and they did not like how staff spoke to them.
- On one ward in Nottingham we heard staff swearing in the office.

## Are services responsive to people's needs?

Good



### We rated responsive as good because:

- Care programme approach meetings were held, at which discharge planning was discussed with staff from local services. Discharge planning began soon after admission and most patients had a discharge plan.
- There were pathway bed management meetings every week in the learning disability service.
- Patient bedrooms had been personalised with their own furniture, belongings and photographs.
- There were information boards displaying information in a variety of languages. Information was also available in an "easy read" format with pictures to assist understanding.
- Personal care records respect for cultural preferences for the gender of staff providing care.
- Patients had access to advocacy and chaplaincy services.
- People's religious beliefs were supported through access to the multi faith rooms available on the different sites or through visits from spiritual leaders at their request.
- There was a central complaints policy and complaints investigations had been completed within the prescribed timeframe outlined in the complaints policy.
- There had been an increase in the group of patients with Huntington's disease on Tallis ward which affected the clinical risks on the ward and this was raised as a concern, this was being addressed by staff receiving extra training in this area.
- There were sometimes delays in discharging people back to their home areas due to the lack of appropriate facilities.

# Summary of findings

- The CAMHS service had a number of “extra care” beds, these were generally patients segregated from the main ward area and cared for in isolation. The policy around such practice was ambiguous and this was confirmed by the records we viewed.
- Some of the estate at Northampton was old and there were planned improvement to these environments. We saw the older building we either being upgraded or there were plans to re-provide these service in new builds. This meant that:
  - The older adult wards were a challenge to make feel homely. However we saw they had utilised the ends of corridors to create small areas that were of interest for the patients.
  - Some mixed gender accommodation was in use on some older adults wards, which meant there were not clear arrangements for ensuring that there was same sex accommodation in adherence to guidance from the Department of Health and the MHA code of practice, to protect the safety and dignity of patients.
  - Some of the learning disability wards were not accessible for patients with significant physical disabilities or who requiring wheelchair access.
- There were blanket restrictions in place in several areas across the service this included:
  - On the PICU, there were times when access to bedrooms was restricted. Staff stated this was because of staffing levels.
  - On secure services, there was no patient internet access and access to bedrooms was restricted during the day.
  - At Berkley close we saw that the kitchen was locked and patients had no access to make hot drinks
  - On Althorp ward sweets were not allowed and there were restricted times for hot drinks.
  - On the CAMHS wards, all of the young people were prevented from having sugar and there were restrictions around the length and time of day that young people could make telephone calls.
  - In the learning disability services, cigarette breaks were taken hourly, and drinks were only available at set times. Access to bedrooms was restricted and there was no access to kitchens or sensory rooms unless accompanied by an occupational therapist. Section 17 leave arrangements were linked to the overall generic risk safety system.
- There were several examples where informal patients (people who were not detained under the Mental Health Act (1983)) were asked to sign contracts to access leave and this leave was then authorised on a form.

# Summary of findings

- On some wards there were no examination couches in the clinic rooms, this meant patients were examined in their bedrooms.

## Are services well-led?

### We rated well-led as requires improvement because:

- The board assurance framework and charity wide risk register showed that the provider had identified many of the risks identified during our inspection. However, our findings showed that some of the provider governance systems were not effective. This is demonstrated by variations in the quality of service between locations and also between services in the same locations or core service area.
- In some services we saw that staff morale was mixed.
- Some staff at ward level told us that there was little consultation and involvement regarding changes in the service and they knew some changes were happening but were not aware of the details or timescales.
- Staff in the CAMHS service told us they felt underappreciated by those senior managers and often felt not listened to as the provider was focused on adult services.
- In the learning disability services most ward staff told us that they felt stressed and did not feel valued or supported by the organisation. Staff told us that it was difficult working with high numbers of bureau (bank and agency) staff in very challenging environments.
- The board of St Andrew's Healthcare had undergone significant changes in the past 12 months. To allow for a better challenge from the executives and non-executives the membership of the board was changing. New people were being appointed with health experience to effectively offer this challenge at board level. There was a clear vision for the provider but this had not become embedded at ward level.
- Most staff told us they knew their immediate management team well. While many of the staff were not clear who the senior and executive management team were, people did tell us that the new chief executive officer had more presence in the clinical areas.

## Requires Improvement



# Summary of findings

## Our inspection team

Our inspection team was led by:

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

**Team Leader:** Nicholas Smith, Care Quality Commission

The team included CQC inspectors and a variety of specialists: behaviour nurse therapists, consultant eating disorders psychiatrist, consultant forensic psychiatrists,

consultant learning disability psychiatrist, consultant psychologist, consultant psychologist learning disability, experts by experience as users of services, family carer experts, forensic psychologist, hospital manager, learning disability nurses, Mental Health Act reviewers mental health nurses, pharmacists, quality manager, social workers and a student nurse.

## Why we carried out this inspection

We inspected St Andrew's Healthcare as part of our wave 2 pilot comprehensive mental health inspection programme.

St Andrew's Healthcare was selected as one of the second wave of organisations providing mental health services to enable the Care Quality Commission to test and evaluate its methodology across a range of different trusts and providers.

## How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to

share what they knew. We carried out announced visits between 9 and 12 September. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and with carers, who shared their views and experiences of the service. We carried out an unannounced visit on 24 and 25 September.

## Information about the provider

St Andrew's Healthcare is one the UK's largest charities providing specialist mental health care. The charity has been in existence for 176 years and has tripled in size since the late 1990's. St Andrew's Healthcare provides approximately 1000 in-patient places. The charity has the UK's national secure facilities for adolescents and young adults, women, men and older people. The charity also provides private therapy services for GP referred patients

and medico-legal expertise. St Andrew's Healthcare has eight registered locations serving mental health and learning disability needs, including four hospitals sites in Northampton, Birmingham, Nottingham and Essex.

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

# Summary of findings

Nottingham specialises in men's services for people with mental illness and learning disability

Essex specialises in low-secure provision for men and women with a forensic history or personality disorders. These include men's services, women's services, and a female psychiatric intensive care unit (PICU).

Birmingham provides in-patient mental health services for up to 128 adults aged between 18 and 65. There are eight wards on the site providing care in conditions of medium and low security.

The provider employs more than 4,000 staff across the four hospitals and provides the following core services:

- Long stay/forensic/secure services
- Child and adolescent mental health services
- Services for older people
- Inpatient services for people with learning disabilities or autism
- Psychiatric Intensive Care Units (PICU)

The latest annual return to the Charity Commission indicated that annual income for the charity was £171,000,000 while spending was £161,200,000. For the last five years income has always exceeded expenditure.

St Andrew's Healthcare has been inspected on 32 occasions since registration. Of the eight active locations, two were compliant with all regulations at the time of the inspection. These are St Andrew's Healthcare – Consultancy Service (last inspected February 2014) and St Andrew's Healthcare – Birmingham (last inspected June 2013).

The overall compliance rate for St Andrew's was calculated against the locations for which reviews of compliance had been completed by August 2014. The rate of 25% of locations inspected, judged to be compliant is notably lower than the independent healthcare national average compliance rate of 90%.

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

Prior to the inspection we met with people who use services in focus groups. We also held further focus groups at each site during the inspection week. We attended community meetings, service user forum meetings and held individual conversations with people. We also reviewed information shared with the CQC directly by people using the service through our website and by telephone. During the inspection we also received feedback through people completing the CQC comment cards.

We received mixed feedback from people about the quality of service provided by the provider. Some people told us they felt the staff were supportive and that they had received a good service which met their needs. Patients told us about the progress they were making. Other people told us they felt that there were not sufficient staff to meet their needs and to facilitate activities, especially section 17 leave for people detained under sections of the Mental Health Act.

Some services received positive feedback. We met with young people in the CAMHS and neuropsychiatry service who told us how they appreciated the support provided to them and how the staff had continued to work with them when other people had given up on them.

We received mixed feedback about the quality of the staff. People told us generally that they felt safe on the wards and had good care. However they told us they felt the high use of bureau (bank and agency) staff being used meant that there were often staff on duty who did not know them or how to keep them safe. They said that staff listened to them and were good at defusing situations which helped people to feel safe. However some people told us they felt ward staff should spend more time interacting with them. Some of the people we spoke with told us they felt their care would be improved if there was more consistency in the person supporting them. Not all people we spoke to know who their named nurse was.

Many people we met with told us they were concerned about the quality of the environment in some of the Northampton wards. For example, people we met with

# Summary of findings

told us they had recently moved and the change of environment had meant that they had moved to new wards without en suite bathrooms and now had to use shared facilities.

People from another ward told us that they had moved from a ward where they had had en suite facilities and outdoor space to a new ward where neither were available. One person told us they were not happy to share the bathrooms. People told us they had not been involved in the discussions regarding the move.

Several of the low secure wards did not meet NHS England environment standards so were part of the organisation's project to upgrade wards to meet the standards required.

Some of the people we met with at a focus group for young people told us that sometimes they got bored as there were not enough staff to support them to do regular activities. Several of them also told us they did not like the food, as this was not food young people would eat. However, other people told us they enjoyed the food provided. Several people told us that they had not agreed with their plans about controlling their weight. For example banning sugar from the adolescent wards.

In the Nottingham services we met members of the "our voice" service user representatives' focus group who told us that ward managers were not visible and there was not enough nurse led activities. Whilst patients understood the safeguarding process they were frustrated by the length of time it took to receive the outcome of the safeguarding reviews. The group stated that generally patients did not feel safe at Nottingham

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

In the focus groups and meetings attended in Northampton we were told that staff were caring and understood them. Most patients felt safe and had good care. They said that this helped them to trust the staff. Some people told us that activities that they enjoyed were offered. Whilst others told us that they wanted a wider range of activities provided and felt that they were sometimes disadvantaged by some people requiring more staff time and attention due to the acuteness of their illness, which led to cancellation of activities and section 17 leave.

Some patients told us that they felt angry and frustrated by how they are treated, stating that staff do not listen to them and were rude to them. We were told that restrictions from the overarching risk safety system made them feel frustrated and angry.

We also held telephone interviews with carers who told us that there was limited carer support and involvement; however other carers told us that they praised the dedication, knowledge and professionalism of staff.

## Good practice

### In the older persons service

- Practice incorporated latest research and evidenced-based guidance to ensure the most effective care was being provided.

### In the neuropsychiatry service

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

- Introduction of technologies on the ward such as tablet computers to improve the patient and staff experience.
- A strong model for future plans of the service meant that at a strategic level it was clear where the development would lie
- People on Tallis ward had been encouraged to write advanced statements and plan their future care should they lose capacity to make decisions regarding their care in the future.

# Summary of findings

## In the PICU

- Additional systems were in place to review enhanced support and seclusion/segregation, such as arranging for doctors across wards to give a second opinion/independent review on the management of these incidents.

## At the Birmingham location

- One person in Hawkesley ward was studying for a Masters. The hospital had supported the person to get a laptop, which helped them in their studies.

- People in Northfield ward were supported to access community based college courses and work placements.
- Each ward had at least one 'buddy'. This was a person who used the service and they showed people around the ward on admission which helped them to feel safe.
- People who used the service were involved in recruiting new staff.

## Areas for improvement

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

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

The provider must take steps to ensure that each patient is protected against the risks of receiving care or treatment that is inappropriate or unsafe.

- The provider must ensure that patients have positive behaviour support plans where appropriate.
- The provider must ensure that care in the adolescent service is planned in accordance with children's rights.
- The provider must ensure that care and risk are assessed, planned and managed based on individual needs.
- The provider must ensure that all care and treatment options are discussed and explained in a way that the person who uses the service understands especially in the learning disability service and CAMHS services.
- The provider must ensure that patients and their carers/family are involved in care planning and risk assessment.

The provider must ensure that the Code of Practice Mental Health Act 1983 is always being adhered to in the following areas:

- Sitwell ward was not consistently documenting the patient's review of restraint.
- Sitwell ward was not following St Andrew's Healthcare Seclusion policy with regard to seclusion reviews of patients.

- Patients' on Fairbairn and Rose wards were not receiving information about their rights in a timescale or format that would aid understanding.
- In Nottingham current responsible clinicians had not documented the capacity and consent.
- In Nottingham they had not documented the outcome of SOAD reviews of treatment, statutory consultees had not recorded their discussion with the SOAD.
- Patients using services had not been provided with a copy of their section 17 forms and leave facilitated.
- Blanket searches had occurred without take into account individual risk and consent.
- The provider must ensure that all accommodation is in line with best practice guidance for same sex accommodation. There were no clear arrangements for ensuring that the same sex accommodation in the older adults service was in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety and dignity of patients.
- The provider must ensure that patients who are deaf or have hearing loss are cared for by staff able to communicate with them effectively.

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

- The provider should ensure that people who were not detained under the Mental Health Act (1983) and remain informal should have access to leave without conditions
- The provider should review the use of restrictive blanket practices on wards For example,
  - The locking of patient bedroom doors and corridors at specific times.

# Summary of findings

- Specific times for cigarette breaks and drinks.
- The routine searching of patients who return from leave.
- Supervised visits for all patients at the Birmingham location
- The provider should ensure that access to seclusion and all seclusion facilities are fit for purpose.
- The provider should ensure that a structured comprehensive handover takes place between staff teams and a record of these are kept.
- The provider should address the impact that irregular staffing is having on patient care. This includes continuity of care, accessing activities, outside space and leave arrangements.
- The provider should ensure that emergency resuscitation drills take place as part of ongoing staff training.
- The provider should ensure that the risk safety management system is reviewed to ensure that it is person centred.
- The provider should make sure that information about people's care and treatment is provided in a format that each person who uses the service can understand.
- The provider should ensure that a review takes place of the mix of patients on Tallis ward, where people with Huntington's disease were placed with people with acquired brain injury, and ensure the skill mix of staff meets the needs of patients.
- The provider should ensure that records of general observations and 15 minute observations on Sherwood ward are accurate and complete where they are necessary.
- The provider should engage with staff to understand why morale is low in the learning disability services.
- The provider should review patients' long term placement options for those who have been in extra care or single bed wards facilities for prolonged periods of time
- The Provider should insure that information is provided in formats that people understand.
- The provider should review the policies and procedures to ensure they are appropriate for and meet the needs of the adolescent service.
- The provider should ensure that the maintenance issues identified at Essex around the hospital's drainage system and excessively warm ward areas are addressed effectively for the comfort of people and staff.
- The provider should ensure that all staff have appropriate access to those electronic care and treatment records that they require to do their job effectively.
- The provider should ensure patients know who their named nurse and care coordinator is and regular meetings take place.
- The provider should ensure that ward staff only use acceptable language and behaviours.
- The provider should ensure that patients are fully engaged in planned activities.
- The provider should make sure that more staff are trained to use the gym so they can safely support patients.
- The provider should ensure that people who may not have capacity to make decisions are assessed as required to ensure that the appropriate safeguards are in place.
- The current Independent Mental Health Advocacy (IMHA) service should be reviewed to ensure that all patients can access this service if they choose to.



# St Andrew's Healthcare

## Detailed findings

### 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 rated the safe domain as requires improvement because:

- There were concerns identified in some of the older buildings and services were operating on the understanding that there would be significant improvement to these environments. The older building we either being upgraded or there were plans to re-provide these service in new builds.
- In Essex, on Audley ward, actions from ligature audits had not been taken. On Maldon ward care and treatment records were incomplete in respect of one patient's enduring physical healthcare needs.
- In Nottingham, there were blind spots in all seclusion rooms and some bedrooms.
- In Birmingham, medicine in the pharmacy was not stored and disposed of safely. There was not a way to

ensure that food was safely stored. The seclusion room in Northfield was not safe at the time of our inspection. The provider took immediate steps to make this room safe during the inspection.

- The provider was maintaining safe staffing levels in inpatient services with the use of bureau (bank and agency) staff. The provider tried to ensure that bureau staff(agency and bank nurses) used were familiar with the ward and knew the people who used services. However this was not always possible and some patients told us that this meant that they did not feel safe or were not able to take leave.
- At night ward nursing cover was a concern as regular staff were frequently moved to wards to ensure that other wards had enough staff.
- There was limited medical cover on nights. One doctor provided cover to the whole of the Northampton site between 11pm and 8am.
- In the children and adolescents mental health service, people were being restrained in the prone

# Detailed findings

(face-down) position to manage disturbed behaviour. We also found that risk assessments and care plans for prone restraint were not always in place.

- There were concerns around the use of seclusion these included reviews were not being consistently documented after patients had been secluded and staff not following the seclusion policy. The seclusion room on some wards was used for “time out” in contradiction to St Andrew’s seclusion policy.
- Some staff did not know the safeguarding process or where they could find out about current ward issues.
- There was an incident folder available on all wards, staff who had not attended meetings had sight of this and were asked to sign when read. However this was not consistently applied across all wards.
- The CQC had not been sent required notifications relating to incidents affecting the service or the people who use it within the learning disability service.

## Our findings

### Safe and clean ward environment

The ward layout did not always allow staff to observe all parts of ward. This was due to the mix of accommodation used to provide in patient services.

At the Northampton site the ward accommodation was located in a mix of new purpose built accommodation and older estates some of which was in a large grade 2 star listed building. We identified concerns in the older people’s services in the older buildings the risk in this service was increased as the accommodation was mixed sex and it breached best practice guidance for same sex accommodation.

On the Fairburn ward we saw that there were areas of the seclusion room which were not visible or covered by the CCTV monitoring the area. The observation window was not large enough to allow staff to use sign language to communicate with the deaf patients on the ward.

At the Essex location the seclusion room on Audley ward did not allow for observations to be maintained if someone was using the en suite facilities. There were plans in place to address this concern.

Most ligature points had been identified and risk assessed to reduce any risk of patients harming themselves. In the Essex service on Audley ward the ligature risk assessment had been completed. The risk assessment identified actions to mitigate the risks which include hourly observations. These risk assessment records were not available when we requested to see them.

Not all ward areas in Northampton included a fully equipped clinic room. Each clinical area had access for full emergency resuscitation equipment and drugs. We saw that checks of the equipment had been completed. Ninety-two percent of the required staff had completed intermediate life support training. However we found the following:

- The provider did not always undertake the required drills to test the efficiency of the response and training at the Northampton, Birmingham and Essex sites.
- The equipment checks were not recorded at the Nottingham site.
- Hazelwell ward was in a separate building on the Birmingham site did not have any emergency equipment. The provider purchased this equipment during the inspection.

The majority of ward areas we inspected were clean. The wards had suitable and well-maintained furnishings. The furniture was suitable for the different patient groups throughout the service. The provider undertook three monthly audits of cleanliness at the Birmingham site.

However at Birmingham on Edgbaston Ward patients complained to us that the chairs were not clean and we saw that they were stained.

All sites had completed environmental risk assessments, these were recompleted every three months and where required we saw action plans to address any shortfall.

### Safe staffing

The provider had identified staff recruitment as an issue on the risk register. The controls in place to manage the risk include daily 'flash' reports that highlight gaps between actual and planned ward staff. There was an escalation process for managers in cases of staff shortages. In addition to these, the provider was in the process of employing two additional staff to concentrate on nurse recruitment.

# Detailed findings

The provider had developed a skill matrix for each clinical area which identified staffing levels and ensured the use of enhanced support was appropriate and proportionate to need.

Staff told us that most staffing shortages were filled by the bureau (the providers bank and agency staff).

The provider submitted evidence that showed there were 38,917 occurrences when bureau (bank or agency) staff were required to meet the required ward staffing complement in the three month prior to the inspection. It was only possible to cover 34,176 of these.

The permanent nursing staff headcount was 3244 Whole Time Equivalent (WTE). In the 12 months prior to the inspection 409 people left the provider, which is a turnover rate of 13%. The staff sickness rate was 4% in June 2014.

Recruitment of nursing staff was taking place and two staff were being recruited to oversee this process. Staff worked overtime or they used staff from the hospital bureau (bank and agency) to cover the vacancies.

When staffing fluctuation does happen (for example when a patient needs increased observations, or to attend appointments off site) this is managed locally by the ward managers who are able to deploy staff from other areas to meet these needs.

We reviewed staffing rotas for the three months prior to the inspection and found that staffing levels were in line with the levels identified by the provider.

There was a system in place to enable ward managers to see the staffing levels on all wards.

The impact of moving staff and using bureau (bank or agency) staff was that there were often no staff able to escort people on section 17 leave and during the evening and at night there was not enough regular staff who knew the patients well enough.

There were also problems recruiting staff to some areas, the provider had paid additional money to staff who offered to work in these areas.

We identified concerns with the medical cover for the Northampton site overnight where there was only one doctor providing waking cover with a second doctor on call

to the Northampton site between 11pm and 8am. We were told and found that seclusion reviews were not always completed and when they were completed there were often delays.

## Assessing and managing risk to patients and staff

All care records that we reviewed contained a risk assessment. The majority of these were the HCR 20 (historical clinical risk management-20). These were updated on a regular basis and in response to incidents. Risk assessments were reflected in care plans and we saw evidence of patient involvement in risk planning. We found several examples of positive risk taking to enable people moving towards less restrictive settings.

The provider had policies to support the patient during their admission; these included a policy for supportive observations. Staff we spoke with were able to explain how this policy was implemented. We saw evidence that reviews took place and the level of observation changed as people's risks reduced. We did identify that in some areas these checks were not being recorded.

Staff employed by St Andrew's Healthcare completed physical restraint training. The training details submitted indicated that 89% of all staff were up to date with their training. Staff we spoke with told us that restraint is only used after de-escalation has failed and using correct holds. Staff raised some concerns that the agency staff had not all received the same training so were not always able to assist when required. In the neuropsychiatry service we saw staff had a good understanding of de-escalation techniques which minimised the use of restraint. All patients had care plans which specifically referred to their needs related to seclusion and restraint when it was needed, which ensured that people's needs were met.

We saw arrangements were in place to provide guidance to medical and nursing staff using rapid tranquillisation. Staff routinely made physical health observations after patients were administered rapid tranquilisation and recorded these in care records.

Seclusion was being used appropriately. However there are some improvement required in relation to practice these includes ensuring that:

- Rooms are safe and observations can be maintained.
- Records are maintained appropriately for each episode.

# Detailed findings

- The practice of moving people in restraint between clinical areas for seclusion is reviewed and the methods used are the safest and least restrictive at all times.
- That medical reviews take place according to the requirements of the code of practice Mental Health Act 1983.
- Staff are clear of the difference between isolation, segregation, time out and seclusion and that any patient who is restricted is subject to additional safeguards.
- Patients who are deaf or have a hearing impairment can be effectively communicated with whilst in seclusion.
- Post seclusion reviews are always completed.

The safeguarding policy was available on the intranet. In the clinical areas we saw safeguarding flow charts, telephone numbers, emergency contact details and other safeguarding information.

Staff from all services demonstrated that they knew how to make a safeguarding alert. We saw that staff had made a safeguarding alert when appropriate to ensure that people who used the service were safeguarded from harm. Staff told us and records showed that all staff received training in safeguarding vulnerable adults from abuse. Training was updated annually. We tracked through some safeguarding incidents. These had all been appropriately managed.

However this was not the case in the learning disability service or the child and adolescent learning disability wards. In these areas staff did not have a good knowledge of the safeguarding policy or procedures. Some agency staff did not know the safeguarding process or where they could find this information.

Across the service 94% of the required staff had attended level 1, safeguarding training. However only 62% attended level 2 and 28% level 3 training.

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

In the Essex service medicines 'champions' had been nominated on each ward to take responsibility for improving the standards of medicines management.

In the Northampton services we also checked medicines management by looking at the storage, dispensing and recording of medicines. All the records checked were complete and the systems in place to manage medicines were safe. Where people were prescribed "as and when required" medicines there was a clear protocol in place to ensure staff were aware of the circumstances the medicines should be administered.

In Nottingham patients did not always receive their medicines promptly. This was because there were no facilities to dispense medicine on-site. When medicines were not available on site then a courier collected these from the Northampton site.

In Birmingham a large number of controlled drugs (CDs) which were no longer required were stored in the pharmacy. The provider's controlled drugs procedure, dated June 2014, is clear CDs should be regularly disposed to prevent the build-up of supply.

## Reporting incidents and learning from when things go wrong

All staff were aware of the process to report incidents through the electronic system used by the provider and they were able to explain to us how they did so and what happened to reports which they made. Team meetings took place on the ward monthly and learning from incidents formed a part of the discussions which happened regularly. However, no regular meetings for night staff took place. This meant that there was a risk that night staff would not have access to the same learning structures as staff that were present during the day.

In the intensive care service we saw an example when practice had changed following an incident. This had led to the employment of a nurse who managed the assessed physical healthcare needs of people who used this service.

At Northampton in the learning disability service we were concerned that the CQC have not been sent required notifications relating to incidents affecting the service or the people who use it, in line with requirements of regulation 18 of the Health and Social Care Act.

In CAMHS we identified an incident where a number of patients had become anxious, distressed and agitated at the same time. We spoke with staff regarding learning from the incident, and identified that the learning had not been shared with other parts of the service or with other locations.

## Detailed findings

In Birmingham whilst there was an open culture of reporting medicine errors, staff were not always informed of the outcomes so they were not able to learn and change practice.

In Essex staff told us that they felt supported in reporting incidents and that lessons learnt were discussed in both

individual supervision sessions and within team meetings. 'Think back, move forward' forms were completed by the patient with staff support following an incident. This assisted in reflective thinking and practice

## 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

#### We rated effective as good because:

- Care for individuals was planned by effective multi-disciplinary working (MDT). People using the service were supported and encouraged to make choices about their care.
- In the older adult services care plans were detailed, personalised and described the care we observed being provided.
- Care plans relating to physical health which included liaison with the onsite GP services.
- There was good use of the "my shared pathway" tool which embedded patient involvement and were written from the patient point of view.
- The provider was providing evidence based treatments in line with best practice guidance. The provider assessed outcomes for people using of the Health of the Nation Outcome Scales (HoNOS) secure assessment tool.
- The medication was managed in adherence to professional guidance. However concerns were raised about the storage and disposal of medication at the Birmingham hospital.
- Audits were being undertaken including infection control, medication records and clinic room equipment.
- Staff received regular supervision. In some areas there was an additional reflective practice session facilitated by the psychologist.
- Appraisal of performance was undertaken annually.
- The hospital had access to a GP services, a practice nurse an advanced nurse practitioner, as well as podiatry and dentistry services.
- The provider delivered and monitored a programme of 'mandatory' training for their permanent and bureau staff; 90% or more of the staff had completed this training.
- Care and treatment was delivered through a multi-disciplinary team that included social workers, occupational therapists, psychologists, speech and

- language therapists and medical and nursing staff. Staff attended ward rounds and Care Programme Approach (CPA) meetings regularly and were actively involved in people's treatment and care.
- The Mental Health Act paperwork for patient's was accurate and complete in all sections. However some informal patients were asked to sign a contract for granted leave, which does not reflect the Mental Health Act.
- People who were detained under sections of the Mental Health Act had access to an independent mental health advocacy services. However in Birmingham patients told us that they sometimes had difficulty accessing the independent mental health advocate (IMHA) as there was only one IMHA for the 128 bed hospital.
- Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). We saw that where required capacity assessments had been completed and reviewed and were related to specific issues.

### Our findings

#### Assessment of needs and planning of care

We looked at over 100 care records and found most patients had a full assessment of their care needs. Care plans were detailed, personalised and accurate to the care we observed being provided. Care provision was reviewed on a weekly basis and changes made to ensure staff were able to provide care that fully met the patient's needs. We saw care plans relating to physical health which included liaison with the onsite GP services. However in the learning disability service we looked at ten electronic patient care records. Care plans were in place to assist with the management of violence and aggression. However these were generic and not always person centred or updated regularly.

On some wards we saw people had been encouraged to document advanced decisions into the care plan

## Are services effective?

documentation which was particularly helpful for people with degenerative conditions like Huntington's disease and it evidenced people's involvement in planning their own future care.

The care records indicated that a physical health check had been undertaken on admission. We saw that there were care plans in place to monitor specific physical health problems across the hospital sites.

### Best practice in treatment and care

Staff in the neuropsychiatry services had an understanding of current relevant National Institute for Health and Care Excellence (NICE) guidelines and information was discussed at management level to ensure that policies on the wards reflected these guidelines.

The provider had developed policies for staff to follow which referenced NICE guidance for example in chronic disease monitoring and in acute and chronic wound care (for people who self-harm).

Patients were being offered therapy as recommended by national guidance; such as cognitive behavioural therapy (CBT). Some staff were being trained to deliver CBT. Other therapies were also available these included phobia therapy, 'stop and think' problem solving groups, mindfulness and advanced relapse prevention. In some services, specific offender treatment was also being provided.

We looked at how the CAMHS service followed best practice in relation to managing challenging and complex behaviours and found improvements are required. For example people who had complex challenging needs did not have positive behavioural support plans in place. The guidance published by the Department of Health Positive and Proactive Care: reducing the need for restrictive interventions April 2014 sets out the expectations of providers to minimise and reduce the need for physical intervention.

Nursing and support staff we spoke with in the CAMHS service had limited understanding of positive behaviour support. Other staff such as psychologists told us training was being developed. We were concerned many patients had been in the service for many years and yet did not benefit from this approach.

We looked at how the service followed best practice in relation to managing challenging and complex behaviours

and found improvements are required. For example people who had complex challenging needs did not have positive behavioural support plans in place. The guidance published by the Department of Health Positive and Proactive Care: reducing the need for restrictive interventions April 2014 sets out the expectations of providers to minimise and reduce the need for physical intervention.

Nursing and support staff we spoke with had limited understanding of positive behaviour support. Other staff such as psychologists told us training was being developed. We were concerned many patients had been in the service for many years and yet did not benefit from this approach.

There was an expectation that every patient be offered 25 hours of meaningful activity a week. In the male forensic, learning disability, neuropsychiatry services in Northampton and at the service in Nottingham and Birmingham activities were often cancelled. The reason given for this was a lack of staff with the skills to facilitate these activities.

In the Nottingham hospital, data for the first quarter of the year showed almost one third of activities planned were not taken up by patients. The patients we spoke with told us that there were not enough activities for them to do. There was no evidence that the offered activities had been reviewed to understand why the patients had refused to take part in these.

Outcomes for people were assessed through use of a range of multi-disciplinary assessment tools designed to monitor people's progress and promote recovery. These included:

- Health of the Nation Outcome Scale (HoNOS),
- Model of Human Occupational Screening Tool (MoHOST),
- The Recovery Star
- Swansea Neurobehavioral Outcome Scale (SASNOS)
- The Overt Aggression Scale – Modified for Neurorehabilitation (OAS-MNR)
- St Andrew's Sexual Behaviour Assessment (SASBA).

The provider submitted information which shows that Thornton ward has been successfully accredited by AIMS (Accreditation for Inpatient Mental Health Services). The

## Are services effective?

accreditation was given on 12 July 2014. AIMS is a standards based accreditation programme designed to improve the quality of care in inpatient mental health wards.

A number of St Andrew's Healthcare locations took part in the Quality Network for Forensic Mental Health Services review and are listed below:

- Medium Secure William Wake House
- Medium Secure Smyth House
- Medium Secure Malcolm Arnold House
- Medium Secure Lowther
- Medium and Low Secure Birmingham
- Medium and Low Secure Nottinghamshire
- Low Secure Essex

This network serves to identify areas for improvement through a culture of openness and enquiry. The model is one of engagement rather than inspection. The network aims to facilitate quality improvement and change in forensic mental health settings through a supportive network and peer-review process.

At Northampton, patients had access to a GP, practice nurse and advanced nurse practitioner as well as podiatry and dentistry which ensured that people's physical healthcare needs were met.

An advanced nurse practitioner was being recruited for the Nottingham hospital.

### Skilled staff to deliver care

St Andrew's Healthcare employs over 4000 staff. These come from a range of mental health disciplines providing input to ward teams including; doctors, nurse, occupational therapists, psychologists, social workers, pharmacists.

Staff were being supervised and supervision sessions are recorded. Staff told us they had regular supervision and this included clinical and managerial supervision.

Since December 2012, 31 doctors have been revalidated with nine deferred due to insufficient evidence.

The provider delivered and monitored a programme of 'mandatory' training for their permanent and bureau staff 90% or more of the staff had completed this training.

Managers were able to track whether staff had completed their mandatory training; any non-attendance was managed through the supervision process.

On Fairbairn ward, where patients are deaf or have a hearing loss, staff that had been trained to sign were moved from the ward. This meant that patients were not always receiving care from people who could communicate with them.

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

As part of the inspection we observed handovers. Handovers explained the care required for each patient and their current presentation. Information was brief but extra details given where the patient's presentation required it.

Staff worked in two teams. This meant that staff usually worked with those on the same team. Handovers took place verbally and the information from handovers was not always recorded. This meant that there was a risk that important information may not be shared.

We observed a night to day staff handover in which minimal handover of patient information was given relating to the patients, and highlighted behaviours that should be observed. The information was not provided by the nurse in charge of the ward handing the care over but by an unqualified member of staff.

Agency nurses were expected to read notes during the shift to catch up on the detail. However, they did not have access to the electronic notes where this information was stored.

At the Essex hospital staff told us if they had been off duty from the ward for more than three consecutive days the nominated safety nurse gave them a full handover and a health and safety checklist was completed to ensure that staff were aware of current care needs and risk behaviours. The handover was being recorded on a nursing handover sheet. This was based on the relational security explorer, from the 'See, Think, Act' Department of Health Handbook.

Multi-disciplinary meetings were held weekly and allowed for in depth discussion about care which involved the patients and relatives (where possible). At these meetings we saw care needs, safeguarding, medication, risks, forward and discharge plans were discussed.

A relative we spoke with told us the team on the ward liaised well with her relative's professional team in their home area to ensure the care was effective and were accurately informed of their progress. They also told us the home area team was invited to reviews on a regular basis.



## Are services effective?

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

St Andrew's Healthcare retained 24 independent 'hospital managers' as required by the Mental Health Act. We were told that the hospital managers had all completed training to ensure that they have the skills and knowledge to undertake their duties effectively.

We visited all of the wards where patients were detained. We reviewed a range of Mental Health Act files for people detained under a variety of sections of the MHA. There were systems in place to scrutinise detention papers to make sure they followed the MHA and we found the detention papers appeared to be in order.

Staff training in Mental Health Act (MHA) indicated that 92% of the required staff had completed this training and this was renewed annually.

Patients were given their rights in relation to their detention every six months. Patients were knowledgeable about their right to an independent mental health advocate IMHA.

There were several issues across the service with following the MHA and Code of Practice, these included:

- Capacity decisions for patients who were consenting to treatment had not been completed by their current responsible clinician (RC).
- Some patients had not been informed by their responsible clinician of the outcome of a second opinion appointed doctor (SOAD) visit; nor had the statutory consultees recorded their discussion with the SOAD.

- When a patient had not understood their rights we found no evidence of further repeated attempts to explain these.
- Some patients were granted ground leave under section 17 of the MHA.
- Some patients were not being given copies of their section 17 leave forms and their leave was not always being evaluated.
- Some patients who were not detained under the Mental Health Act (1983) were being granted leave off of the ward.

### Good practice in applying the MCA

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

Some staff told us that when they had made referrals from authorisations under the Deprivation of Liberty safeguards (DoLS) there had been a delay from the relevant local authorities in providing assessors due to the influx of referrals following the Cheshire West judgement.

All staff we spoke with were able to tell us in detail how this related to the patients. In reviewing the care records, detailed capacity assessments relating to different aspects of the patients life and care provision were recorded. These were reviewed at the weekly team meetings.

## Are services caring?

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

### Summary of findings

#### We rated the caring domain as good because:

- Most people told us that staff were approachable and they gave them appropriate care and support. This was supported by the care interactions that we observed.
- During our visit, we witnessed several occasions where staff responded to a patient in distress. They did this discreetly and protected the dignity of the individual.
- Patients we spoke with told us they were happy and staff were great, kind and caring towards them. A relative we spoke with spoke highly of the staffs' caring attitude despite the challenges they faced on a daily basis.
- The provider had systems to encourage people to be involved in their assessment, care planning and reviews through use of recovery tools such as 'my shared pathway'.
- People had the opportunity to attend a hospital based 'service user forum' and ward based community meetings.
- Patients' views were included in care plans and also included the views of relatives where appropriate. Notes from multi-disciplinary meetings evidenced relative and patient involvement.
- There were some barriers to active involvement for friends and families due to the distance that some people were away from their families.
- On admission, a patient received an information pack about the ward which included pictures to assist them to understand the content.
- We saw patients' views were included in care plans and this included relatives where appropriate. However we found the following exceptions:
  - In the male forensic service, patients' views were not consistently documented in clinical records.
  - In the learning disability service, there was little evidence that patients or their carers were actively involved in writing or reviewing care plans. Most

patients did not have a copy of their care plan or knew what their goals were. Those who did have care plans did not have these in an accessible format.

- Independent advocacy services were available to all patients. However in Birmingham patients told us that they sometimes had difficulty accessing the Independent Mental Health Advocate (IMHA) as there was only one IMHA for the 128 bed hospital.
- In the learning disability services at Northampton we observed little activity or interaction between staff and patients on the wards we visited. Some patients' felt angry and frustrated by how they are treated, stating that staff did not listen to them and they did not like how staff spoke to them.
- On one ward in Nottingham we heard staff swearing in the office.

### Our findings

#### Kindness, dignity, respect and support

During the inspection we observed staff engaging with patients in a respectful and friendly manner. We witnessed several occasions where staff responded to a patient who was in distress and they did so discreetly and appeared to be always mindful of patient dignity.

On many of the wards there were different engagement activities being offered. These included, cooking, craft activities, and indoor and outdoor sporting activities. However in some services we noted that some care was delivered in a neutral manner with little interaction between the member of staff and the person who used the service. On one ward, this included staff sitting away from the patients.

Patients we spoke with told us they were happy and staff were kind and caring towards them.

A relative we spoke with spoke highly of the staffs' caring attitude despite the challenges they faced on a daily basis. They told us the staff always appeared happy and the patients were relaxed with them.

## Are services caring?

In the adolescent service we saw staff engaging patients in age appropriate activities such as table tennis, games and conversation. All of the wards we visited had a calm and relaxed atmosphere where it appeared both staff and patients had a mutual respect for each other. The young people we spoke to told us “they really help me, I wouldn’t be as well now if it wasn’t for them”. “You get on with some better than others but they are all good, nobody treats us bad”.

Staff were able to tell us about the individual needs of patients and the support they required in different situations. We saw patients had attended church services and noted the contact details were available for leaders of other religions. Information on the boards was in different languages and an interpreter service was available.

Some staff on the learning disability wards told us that they were concerned that the restrictive routines in place affected how they were able to care for patients individually, stating that the need to meet the 25 hour activity target took priority over what the individual might want to do.

Whilst we were on a ward in Nottingham we heard staff swearing in the office; this could be heard by the patients.

Some patients in the learning disability service told us they felt angry and frustrated by how they are treated by staff, they told us staff did not listen to them and they did not like how staff spoke to them.

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

On admission, a patient received an information pack about the ward which included pictures to assist them to understand the content. We saw how this pack was personalised and included information about care reviews,

how to complain, the ward activities and names and pictures of their care team. On the PICU one patient told us how they had been involved in developing the booklet for the ward.

We observed multi-disciplinary team (MDT) and care programme approach (CPA) meetings and saw that patients had been involved in discussions about their care needs and that the views of family members had been sought.

Patients were offered copies of their care plans and we saw that where someone’s view differed from those of the care team, that was recorded. However, on the learning disability service we saw little evidence that patients or carers were involved in care planning. Most patients in this service told us they did not have a copy of their care plan and could not identify goals.

In Nottingham, patients told us that they were involved in their care plans we were told “Staff sit with me and review my care plan with me, then I sign it”. On Rufford ward care plans were not in an accessible format for the patient and staff told us that most people were not involved in developing these plans.

Independent advocacy service (Voiceability) was available to all patients. Each ward had an advocate who visited regularly. Advocacy could also be contacted by telephone. Patients told us that they knew how to contact an advocate.

In Birmingham patients told us that they sometimes had difficulty accessing the Independent Mental Health Advocate (IMHA) as there was only one IMHA for the 128 bed hospital.

# 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 rated responsive as good because:

- Care programme approach meetings were held, at which discharge planning is discussed with staff from local services
- Discharge planning began soon after admission and most patients had a discharge plan.
- There were sometimes delays in discharging people back to their home areas due to the lack of appropriate facilities.
- There had been an increase in the group of patients with Huntingdon's disease on Tallis ward which affected the clinical risks on the ward and this was raised as a concern, this was being addressed by staff receiving extra training in this area.
- The CAMHS service had a number of "extra care" beds, these were generally patients segregated from the main ward area and cared for in isolation. The policy around such practice was ambiguous and this was confirmed by the records we viewed.
- There were pathway bed management meetings every week in the learning disability service.
- Some of the estate at Northampton was old and services were operating on the understanding that there would be significant improvement to these environments. We saw the older building we either being upgraded or there were plans to re-provide these service in new builds. This meant that:
  - The older adult wards were a challenge to make feel homely. However we saw they had utilised the ends of corridors to create small areas of interest.
  - Some mixed gender accommodation was in use on some older adults wards.
  - Some of the learning disability wards were not accessible for patients with significant physical disabilities or who requiring wheelchair access.
- Patient bedrooms had been personalised with their own furniture, belongings and photographs.

- There were information boards displaying information in a variety of languages. Information was also available in an "easy read" format with pictures to assist understanding.
- Personal care records respect for cultural preferences for the gender of staff providing care.
- Patients had access to advocacy and chaplaincy services.
- People's religious beliefs were supported through access to the multi faith rooms available on the different sites or through visits from spiritual leaders at their request.
- There was a central complaints policy and complaints investigations had been completed within the prescribed timeframe outlined in the complaints policy.

However we also noted areas requiring improvement.

- On some wards there were no examination couches in the clinic, this meant patients were examined in their bedrooms.
- There were blanket restrictions in place in several areas across the service this included:
  - On the PICU, there were times when access to bedrooms was restricted. Staff stated this was because of staffing levels.
  - In secure services, there was no patient internet access and access to bedrooms being restricted during the day.
  - At Berkley Close we saw that the kitchen was locked patients had no access to making hot drinks.
  - On Althorp ward sweets were not allowed and there were restricted times for hot drinks.
  - On the CAMHS wards, all of the young people were prevented from having sugar and there were restrictions around the length and time of day that young people could make telephone calls.
  - In the learning disability services, cigarette breaks were taken hourly, and drinks were only available at set times. Access to bedrooms was restricted

# Are services responsive to people's needs?

and there was no access to kitchens or sensory rooms unless accompanied by an occupational therapist. Section 17 leave arrangements were linked to the overall generic risk safety system.

- We saw several examples where informal patients (people who were not detained under the Mental Health Act (1983)) were asked to sign contracts to access leave and this leave was then authorised on a form.

## Our findings

### Access, discharge and bed management

St Andrew's Healthcare provides out of area treatment to patients placed by NHS England and local clinical commissioning groups (CCG's). This means that all admissions are planned (even those urgent admissions) and only happen when there is a bed available.

The provider does not use leave beds for other people so the bed is always available on their return from leave.

Patients only move wards during an admission episode when this is justified on clinical grounds and is in the interests of the patient. We were told this only takes place after careful consideration by the multi-disciplinary team and the best interests of the patient are always considered.

The provider also has PICU services for male and female patients. These are at the Northampton and Essex sites and are used when local NHS services cannot admit the patient. These are not always close to the home area for people to maintain contact with their family and friends.

From the data submitted by the provider, 56 patients had their discharge delayed in the six months to 31 July 2014. Discharge delays were monitored and St Andrew's staff worked actively with referring authorities to speed discharge. The reasons identified for delaying discharge included, the lack of a suitable bed in the home area, waiting for approval from other gatekeepers including the Ministry of Justice (where a patient had to have detention restrictions reviewed or amended) and delays in putting specialist packages in place to support the individual outside of a hospital setting.

St Andrew's Healthcare as an independent provider is reliant on local health and social care teams to identify move on placements.

A large number of the patients at St Andrew's Healthcare have been detained on sections of the Mental Health Act. A number of these patients are on section in part 3 of Mental Health Act. Part 3 deals with people who have been involved in criminal proceedings. This means that these people will often pass through the levels of security within the hospital before being considered for discharge.

### The ward environment optimises recovery, comfort and dignity

The ward environments differed significantly between the services we visited. The newer and refurbished wards had a range of rooms for providing support and treatment. There were quiet rooms if a patient wanted privacy to make phone calls or receive visitors. There were different areas where people could sit if they wanted to be with other people or to be on their own.

There were plans in progress to upgrade and re-provide the services in the older buildings at Northampton. Some of the services being provided were subject to this work being completed.

The hospital at Northampton is set in extensive grounds providing access to outdoor space. The hospital and some wards had access to a gym and swimming pool.

However, some wards were based in older buildings and these often were not as well-appointed and were without en suite facilities. These wards were not accessible if the patient required wheelchair access.

The wards had information boards containing details of other services including advocacy, local befriending services, treatment options (including medications), local health services and how to make a complaint both in the organisation and external agencies.

Patients from some ward areas felt that the complaints they made were not listened too. They were concerned that following a complaint they did not always get feedback once the investigation had been completed.

There was a choice of food to meet dietary requirements of religious and ethnic groups, for example, halal and vegetarian meals. Snacks were accessible during the day.

# Are services responsive to people's needs?

Each ward had kitchen facilities that could be accessed by patients, all access was escorted and patients were able to prepare hot and cold food and drinks, only if it was part of their occupational therapy plan.

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

Althorp ward and Berkeley Close did not have examination couches in the clinic. This meant that patients who needed to be examined used their bedroom.

In Essex we were told patients were only able to access to fresh air in the garden subject to an assessment of risk.

Most of the wards had access to outside space this comprised of gardens and court yards. For some patients access was limited for example:

- O'Connell and Grafton wards in Northampton did not have access to outside space. We did see staff taking patients from these wards outside. However we were told by staff that a patient could only access outside space dependent on their leave status, risk safety system levels and the ward staffing numbers. Patients and staff told us that these arrangements limited access to outside space.
- In Essex we were told that patients were only able to access fresh air in the garden subject to an assessment of risk.
- In Birmingham we saw that all garden access was restricted and this was being applied to those patients who were able to have unescorted leave out of the hospital. Staff could not say why access to the garden was restricted.

Most of the wards were same sex accommodation. However one of the older adult services was not compliant with this guidance from the Department of Health and the MHA Code of Practice, we saw male patients walking through the female ward areas to access the garden and patients having to access the baths in the opposite gender area.

## Ward policies and procedures minimise restrictions

In most areas care was personalised and any restrictions for individuals were risk assessed, documented and reviewed regularly. However, we saw that there were some blanket restrictions on some wards we visited these include:

- No patient internet access.
- Kitchen areas that were locked making patients reliant on staff to access hot drinks and snacks.
- Young people were prevented from having sugar due to a healthy eating initiative.
- There were practices on some wards designed to facilitate patients attending groups such as bedroom doors being locked during activity sessions.
- In Nottingham we were told that bedtime was 11pm and there was no smoking or access to hot drinks after this time.

In Northampton we saw several examples where informal patients (people who were not detained under the Mental Health Act (1983)) were asked to sign contracts to access leave and this leave was then authorised on a form which does not reflect the Mental Health code of practice

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

There were information boards displaying information in a variety of languages including in an "easy read" format with pictures to assist understanding. There was also access to language line for spoken interpreting services.

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

We met with a group of family and carers who identified problems with travelling to the services for some relatives who lived a distance away. They felt there was very little information for relatives and carers when a person was first admitted to a St Andrew's hospital.

## Listening to and learning from concerns and complaints

There was a complaints procedure. Patients told us that they knew how to make a complaint on the wards. We saw the complaints records which showed that there had been 369 formal complaints made in the 2 months to July 2014. A total of 39 complaints were upheld. None of the complaints were referred to the Ombudsmen.

## Are services responsive to people's needs?

The provider had identified some concerns around the number and process for complaints. At the March 2014 board meeting these were discussed. It was identified that there were an increasing number of complex complaints that were taking longer to investigate, this was having an impact on the time taken to respond to other complaints. In response to this, a new investigations team had been identified to support the complaints team and to support the registered hospital managers to manage these complaints and support complainants.

The provider is responding immediately to the complainant either verbally or in writing and offering local mediation. It is hoped that this intervention will reduce the number complaints escalated to the formal process.

Patients from some ward areas felt that the complaints they made were not listened too. They were concerned that following a complaint they did not always get feedback once the investigation had been completed.

In the summary of key risks document 2014, the provider identified an issue with demonstrating learning from serious incidents and complaints. The provider said "this issue has been raised in recent warning notices and NHSE assurance meetings, to mitigate this risk the provider has introduced Root Cause Analysis (RCA) training for staff. The provider is also working jointly with NHS England and commissioning bodies to develop a provider wide communication plan for learning, sharing lessons and trend analysis. This will be supported by a dedicated clinical investigations team and the implementation of new ward to board dashboard.

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

## Are services well-led?

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

### Summary of findings

**We rated well-led as requires improvement because:**

- The board of St Andrew's Healthcare had undergone significant changes in the past 12 months. To allow for a better challenge from the executives and non-executives the membership of the board was changing. New people were being appointed with health experience to effectively offer this challenge at board level. There was a clear vision for the provider but this had not become embedded at ward level.
- Most staff told us they knew their immediate management team well. While many of the staff were not clear who the senior and executive management team were, people did tell us that the new chief executive officer had more presence in the clinical areas.
- The board assurance framework and charity wide risk register showed that the provider had identified many of the risks identified during our inspection. However, our findings showed that some of the provider governance systems were not effective. This is demonstrated by variations in the quality of service between locations and also between services in the same locations or core service area.
- In some services we saw that staff morale was mixed.
- Some staff on the ward level told us that there was little consultation and involvement regarding changes in the service and they knew some changes were happening but were not aware of the details or timescales.
- Staff in the CAMHS service told us they felt underappreciated by those senior managers and often felt not listened to as the provider was focused on adult services.
- In the learning disability services most ward staff told us that they felt stressed and did not feel valued or

supported by the organisation. Staff told us that it was difficult working with high numbers of bureau (bank and agency) staff in very challenging environments.

### Our findings

#### Vision and values

St Andrew's Healthcare had identified and published a set of values, beliefs and mission.

#### Our values

We are driven by our charitable mission to provide the best possible care to as many people as possible. Every day we aim to change the lives of individuals and help to build a better society.

#### We believe in:

- a culture of safety, excellence, and compassion
- a whole person approach, integrating physical and mental healthcare
- specialist recovery pathways, achieving the very best outcomes with each patient
- offering outstanding quality and value to our NHS customers
- sustainable not-for-profit growth, investing all surpluses in improved patient care.

#### Our mission

Our charitable mission is to help as many people as possible by:

- promoting healing
- relieving suffering
- meeting the needs of people experiencing mental disorders, including psychiatric illness, developmental disability and brain injury.

The provider strategy was accessible on their website. On each of the wards visited we saw posters with information promoting the provider values and outcomes.



## Are services well-led?

The senior staff recognised that the values concept was something that needed to be developed further to ensure that they become fully embedded at all levels of the service. The provider had recognised that board leadership needed to be focused on healthcare. The provider was in the process of changing the board to put this leadership in place. These changes are required to ensure effective challenge and leadership of high quality care and effective assurance systems.

Most staff knew the senior managers within the organisation. However, some staff told us that they felt a detachment with the senior management. Some staff working in the learning disability service told us that there was little engagement with senior managers or the organisation's values, and they did not feel able to contribute to wider organisational systems.

In the majority of the clinical areas staff were motivated to provide the best practice and high quality care. Many of the staff told us that they felt proud of working for St Andrew's Healthcare.

The provider used email and the intranet to communicate messages to all of the hospitals. Managers held quarterly staff briefing meetings with the hospital director. The hospital director visited the wards regularly and spoke to both staff and patients.

In Nottingham the staff were not sure of the provider's values, beliefs and mission statements. Only Thorsby ward was able to show us its team objectives and had a clear vision for developing a therapeutic community. Staff knew who the most senior managers in the organisation were. Staff told us that visits had been undertaken by senior managers and executives. Patients on the wards told us that they rarely saw the ward managers describing them as being in the back office or in meetings.

### Good governance

The chairman, chief executive and non-executive directors (NEDs) openly acknowledged the need for the board to strengthen their governance structures and reporting. They explained that prior to the appointment of the new chief executive, the board had not received regular reports on quality of services or compliance. These were held to be the domain of the executive. The previous CQC reports which identified non-compliance issues were described as "a wake-up call".

The focus of the board prior to the new chief executive arriving had been upon finance issues, expansion plans, estate and academic links. In addition, the board received feedback on issues raised by patients during visits by members of the court of governors. These were described as commonly relating to issues such as food and facilities. The medical director is the board lead for quality but had not been required to present reports to the Board on quality and compliance.

It was explained that two NEDs attended the audit and risk committee but there was no other NED involvement in the other governance meetings such as the risk management board or the quality and compliance meeting.

The recently appointed chair and chief executive freely acknowledged the need for the board to change its focus and practices in order for it to be assured about the quality of services and their compliance with statutory requirements. It is recommended that the board:

- Reviews the governance structure and puts in place board sub-committees addressing quality and compliance. The membership of these sub-committees should be representative of the whole board.
- Reviews the board meeting agenda to ensure there is regular reporting and scrutiny of quality and compliance issues and, where necessary, remedial action is agreed.
- Review the membership of the board to ensure that there is an appropriate spread of knowledge and understanding of quality and compliance issues across both executive and non-executive directors.

St Andrew's Healthcare, submitted a risk management assurance framework which provided guidance on the providers approach to managing risk. This framework included how senior management and the board of directors ensured there were controls in place to mitigate risks. However this document was received by CQC with "DRAFT" in the name which suggests the framework is not the final version. The provider told us that this was being updated. The policy provided will be approved at their next board of directors meeting on 25 July.

The board assurance framework and risk register showed that several of the risks revealed by our inspection were not identified and that on going risks had not been addressed.

This is demonstrated by:

## Are services well-led?

- A failure to ensure actions following Mental Health Act visits to wards were addressed across the whole of the service.
- A failure to ensure that wards were safe.
  - Not taking action when ligature risks were identified.
  - Not disposing of controlled drugs.
  - Not removing blind spots in seclusion rooms.
- A lack of awareness of and failure to follow policies relating to seclusion, segregation and restraint.

The inspection identified that aspects of governance were working better in different core services and at different locations. In the neuropsychiatry services there were checks to ensure that the management had an oversight of issues on a ward level. A bi-monthly clinical advisory group was attended by lead professionals within the service. The minutes of this group showed that new pathways were being developed and National Institute for Health and Care Excellence (NICE) guidance was integrated into the service planning.

St Andrew's Healthcare had an audit and risk committee that supported the board of directors by providing oversight of financial statements preparation, risk management, healthcare governance and internal control systems. It also oversees the appointment of external and internal audit resource.

There were weekly ward manager meetings and divisional quality and compliance meetings. These were used to feedback and share learning across the service and back to the quality and compliance meeting. Action plans from these meetings were sent back to the ward. However there appeared to be technical issues around accessing these on the electronic system which meant that ward managers could not always access the plans to make the identified changes on the wards.

Following incidents, a 'lessons learnt' meeting was held. Information from these meetings was fed back to ward staff. Ward managers had an understanding of ward risks; these were maintained on a risk register.

There was a lack of locally driven audits and benchmarking on the wards. Staff were not able to provide evidence to demonstrate that they were providing a good and effective service. For example, ward managers were

not able to tell us average lengths of stays on the wards, trends in seclusion, restraint or incidents. Most of the people in leadership roles had not been to look at other similar services to share and gain learning.

Ward managers' meetings and lead nurses' meetings took place across the service to ensure peer support and information sharing took place. Lead nurses took responsibility for auditing services and were able to feedback information resulting from audits and human resource issues. The audits completed resulted in action plans which were published on the intranet. Action plans generated by the audit department were returned to the wards for completion. However, staff told us that delays in the reports being issued, led to actions being completed before the official plans had returned to the ward.

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

There were ward and service risk registers. The managers within the service had a good understanding of where the risks lay and had plans in place to address those issues.

There was a mandatory training plan in place for staff. Wards had a "dashboard" that provided statistical data on the training completed. All of the wards we visited had relevant training plans in place. The majority of staff (over 90%) were up to date with all the required mandatory training. Managers told us where staff had not completed training this was discussed with them during one to one sessions.

Staff told us they received regular supervision, appraisal and reflective learning. Records on the ward demonstrated that these sessions happened on a regular basis.

There were difficulties ensuring that the wards always had the correct staff skill mix to meet patient needs. The wards regularly used high numbers of bureau (bank and agency) staff to ensure wards were staff to safe levels. Staffing requirements were centrally managed through the nursing bureau. Staff were sometimes moved between wards to ensure safe staffing levels across the service.

Incident reporting and safeguarding processes were consistent across the wards. All serious untoward incidents (SUI's) were reported to and discussed and reviewed in the

## Are services well-led?

patient safety group and ward manager meetings. Data from incident and safeguarding reports were collated through both the local and provider wide patient safety groups a record of these was kept.

The Mental Health Act (MHA) administrator regularly scrutinised the MHA detention papers to ensure that patients were appropriately detained there under the MHA.

### Leadership, morale and staff engagement

The sickness absence rate across St Andrew's Healthcare was 4% in June 2014. In CAMHS and at Birmingham this was higher at 5.4% and 5.5%.

In the three month prior to the inspection 34,176 individual staff duty periods were filled by bureau staff (bank or agency staff). There were an additional 4,741 individual staff duty periods that could not be covered.

On most of the wards we visited staff told us the local leadership and team working were good. Staff told us that the high use of agency staff across the wards impacted on team working as this put pressure on the regular staff to meet the needs of the patients and to support staff who were not familiar with the needs of the ward.

Learning disability service staff told us that they felt stressed and did not feel valued or supported. Staff told us that it was difficult working with high numbers of bureau (bank and agency) staff in very challenging environments. The staff we spoke with identified that morale and team performance had been negatively affected over the past year.

### Commitment to quality improvement and innovation

St Andrew's Healthcare had recently introduced a dashboard system to monitor quality and performance at ward level. There were a several groups and forums to monitor quality and performance, and identify trends from incident reporting. These include the patient safety group, clinical governance group, and a quality and compliance group. The records of these meetings showed how information was shared and actions agreed.

In the neuropsychiatry service technology was being used to improve patient experience. On Tavener ward beds which could monitor some physical health checks electronically were being used. Staff were also using tablet computers, to monitor outcome measures electronically at the bedside, saving time for staff by not having to return to a desktop computer to record information.

We met with young people in CAMHS who had been engaged in developing values and behaviours for the 6Cs statements for Compassion in Practice. Compassion in Practice is the Department of Health three year vision and strategy for nursing, midwifery and care staff. The young people had reviewed what the 6C's meant for them for example Compassion – 'Putting yourself in someone else's shoes and "thinking" about how they feel'. The young people told us that they really enjoyed this piece of work and explained how it had made them think about their responsibilities when in hospital.

St Andrew's Healthcare is part of the Quality Network for Forensic Mental Health Services. This network serves to identify areas for improvement through a culture of openness and enquiry. The model is one of engagement rather than inspection. The network aims to facilitate quality improvement and change in forensic mental health settings through a supportive network and peer-review process.

A number of St Andrew's Healthcare locations took part in the review and are listed below:

- Medium Secure William Wake House
- Medium Secure Smyth House
- Medium Secure Malcolm Arnold House
- Medium Secure Lowther
- Medium and Low Secure Birmingham
- Medium and Low Secure Nottinghamshire
- Low Secure Essex

Following these reviews the services had produced an action plan to address standards that are not met.

This section is primarily information for the provider

## 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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010 Care and welfare of people who use services

**How the regulation was not being met:  
In the older persons service in Northampton.**

There were not clear arrangements for ensuring that there was same sex accommodation in adherence to guidance from the Department of Health and the MHA code of practice, to protect the safety and dignity of patients.

In Nottingham, patients using services had not been provided with a copy of their section 17 forms and leave facilitated.

Staffing arrangements were having an impact on patients accessing activities, outside space and their leave arrangements

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

In the learning disability service, patient care and risk was not assessed, planned and delivered based on individual needs. There was an emphasis on generic, restrictive risk management processes, including restricting visitors and leave, which are not in line with current Department of Health guidance, the principles of the Mental Capacity Act or the Mental Health Act code of practice.

**In the child and adolescent mental health service.**

The service had not followed best practice in relation to people have positive behaviour support plans where appropriate.

This section is primarily information for the provider

## Compliance actions

Managers and staff had a very limited understanding of children's rights which meant care was not always planned in accordance with children's rights.

The service had a risk safety management system which was not designed for the specific use of children's services and was not person centred.

Regulation 9 (1)(b) (i) (ii) (iii)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA 2008 (Regulated Activities)

Regulations 2010 Assessing and monitoring the quality of service provision

#### **How the regulation was not being met:**

The shift patterns did not allow for a comprehensive handover and nursing discussion and there were concerns raised in relation to inconsistencies and conflict between the set teams.

Regulation 10 (2)(d)(I)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 11 HSCA 2008 (Regulated Activities)

Regulations 2010 Safeguarding people who use services from abuse

#### **How the regulation was not being met:**

In the forensic services the Code of Practice Mental Health Act 1983 was not always being followed.

Sitwell ward was not consistently documenting the patient's review of restraint

Sitwell ward was not following St Andrew's Healthcare Seclusion policy with regard seclusion reviews of patients

Patients' on Fairbairn and Rose wards were not receiving information about their rights in a timescale or format that would aid understanding.

In Nottingham, blanket searches had occurred without taking into account individual risk and consent.

This section is primarily information for the provider

## Compliance actions

Regulation 11(2)(a)(b)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 16 HSCA 2008 (Regulated Activities)  
Regulations 2010 Safety, availability and suitability of equipment

**How the regulation was not being met:**

Not all wards had resuscitation equipment. There were a number of locked doors, stairs and potentially an unpredictable patient group, which may impact how quickly the equipment arrived where it was needed

Regulation 16(2)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA 2008 (Regulated Activities)  
Regulations 2010 Respecting and involving people who use services

**How the regulation was not being met:**

Risks, benefits and alternative options of care and treatment were not discussed and explained in a way that the person who uses the service understands.

There was not always clear involvement of patients and their carers/family in agreeing care plans and risk assessments and ensuring people have copies of these

Regulation 17(1)(b)(2)(b)(c)(d)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA 2008 (Regulated Activities)  
Regulations 2010 Consent to care and treatment

**How the regulation was not being met:  
In Nottingham**

There was a lack of adherence to the Mental Health code of practice;-

This section is primarily information for the provider

## Compliance actions

Current responsible clinicians had not documented the capacity and consent.

Had not documented the outcome of SOAD reviews of treatment, statutory consultees had not recorded their discussion with the SOAD.

Regulation 18

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing

#### **How the regulation was not being met: In Northampton**

In the forensic service

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

In the learning disability service

There were not always enough members of suitably skilled and experiences staff to care for people safely.

There was high use of bureau (bank and agency) staff who did not always have adequate information about individual patient care needs.

The shift patterns did not allow for a comprehensive handover and nursing discussion and there were concerns raised in relation to inconsistencies and conflict between the set teams.

#### **In Nottingham**

There was inadequate skill mix and deployment of staff to meet the therapeutic needs of patients.

Rufford ward had a ward manager covering two wards and the staff nurse in charge was on their first day on duty and did not know the ward very well.

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

This section is primarily information for the provider

## Compliance actions

Agency staff were not able to take patients on section 17 leave. This meant that permanent staff were often escorting patients whilst agency staff covered the ward areas.

Some agency staff on Rufford did not know the needs of patients. At one point during our visit on Rufford there were not enough staff.

Regulation 22

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 23 HSCA 2008 (Regulated Activities)  
Regulations 2010 Supporting staff

**How the regulation was not being met:**

Some staff did not have training and understanding about safeguarding

Some staff did not demonstrate understanding about appropriate use of seclusion facilities.

Managers and staff had a very limited understanding of children's rights which meant care was not always planned in accordance with children's rights.

Regulation 23 (1)(a)