St Andrews Healthcare

St Andrew's Healthcare - Men's, Adolescent, Neuropsychiatry and Women's service.

Quality Report

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

Overall rating for this service	**Good**
Mental Health Act responsibilities	
Psychiatric intensive care units and health-based places of safety	Good
Long stay/forensic/secure services	Requires Improvement
Child and adolescent mental health services	Requires Improvement
Services for older people	Good
Services for people with learning disabilities or autism	Requires Improvement
Other specialist services inspected	Good

Summary of findings

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Summary of findings

Overall summary

- We found ligature risk and environment audits were undertaken every six months We saw that some ligature risks had been identified and there were contingency plans in place to manage these.
- The clinic rooms were fully equipped and resuscitation equipment was checked regularly and recorded however not all wards had 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.
- Not all wards had a seclusion facility available for use. Grafton and Hereward Wake wards did not have a seclusion room. On Hereward Wake, this meant that a patient requiring seclusion was being transported to a different location by secure transport. We heard on rare occasions the transport was unavailable leaving both the staff and patient at risk.
- We were told that some agency staff and some bureau staff did not have access to the electronic notes system meaning that patient information would not be readily available in an emergency. Patients told us that due to high levels of bank and agency staff who did not know them caused them to be cared for and treated differently.
- Patients told us that the CAMHS service were insufficiently staffed which meant that they were not always able to have their granted leave. Managers agreed that at times it was difficult to ensure the safety of the ward, whilst meeting the needs of the patients.
- Some staff and patients told us that they did not feel safe on the learning disability wards
- We saw rotas which showed the wards were regularly using bank or agency staff, Mackaness had three members or regular staff on duty and six agency staff on the day of our visit.
- Fairbairn Ward management informed us the electronic system did not allow them to specify staff trained in British Sign Language. This meant patients were not always able to communicate effectively with staff to make their needs known.
- Staff received training in de-escalation skills and conflict resolution
- We found that in the CAMHS service prone restraint was still being used when retraining young people. We also found that risk assessments and Care plans around this restraint were not always in place.
- We found that routine restrictive practices were in place to manage risk, behaviours related to daily care and treatments were measured using generic levels.
- On the learning disability ward some staff did not know the safeguarding process or where they could find out about current ward issues.
- Some staff did not demonstrate understanding about appropriate use of seclusion facilities in the learning disability services.
- On Seacole Ward, there were errors in the recording of medication administration
- Sitwell ward was not consistently documenting patients review of restraint
- Sitwell ward was not following St Andrew's Seclusion policy with regard seclusion reviews with patients.
- Staff throughout the organisation were aware of how to report incidents and we saw good examples of staff learning from the investigation of adverse events
- We found that the CQC had not been sent notifications relating to incidents affecting the service or the people who use it within the learning disability service.
- We found in the older adults services that care plans were detailed, personalised and accurate to the care we observed being provided
- We found in the learning disability service some care plans were generic and not person centred, in particular the risk safety system.
- Staff working in the neuropsychiatry services had an understanding of current NICE guidelines.
- The neuropsychiatry services used positive behavioural therapy for the rehabilitation of patients with acquired brain injury.
- Nursing and support staff we spoke with in the CAMHS services did not have any understanding of positive behaviour support.
- There did not appear to be an opportunity for patients to appeal against decisions made about their risk levels, or clear individual behaviour markers and goals for changes in levels.
- Learning disability patients told us that the restrictions around the risk safety system made them angry.

Summary of findings

- We found that the risk based safety system is being used to manage non risk behaviours such as non-engagement.
- We were told that there were issues around maintaining staff on Fairburn ward who were trained in British sign language (BSL). It often occurred that staff were trained up to a level to work with patients, then moved to work on other wards.
- Appraisal of performance was undertaken annually.
- Staff stated that that the training offered by St Andrew's was excellent.
- During our visit, we witnessed several occasions where staff responded to patient's distress and they did so discreetly and appeared to be always mindful of the patient's dignity.
- In the learning disability services there was not a clear and effective system for comprehensive handovers between nursing staff due to the set nursing shifts.
- We found on Tavener ward that informal patients were asked to sign a contract for granted leave, which does not reflect the Mental Health Act.
- Patients on the PICU did not have access to a lockable space in their bedrooms and they did not always have their room key.
- We saw patient's views were included in care plans and this included relatives where appropriate.
- Community meetings were held weekly services where patients could raise issues related to the ward, minutes were available for us to view.
- There was little evidence that patients or their carers were actively involved in writing or reviewing their care plans on the learning disability wards. Most patients did not have a copy of their care plan or knew what their goals were. Those that did have care plans on Bradlaugh found that it was not in accessible format.
- We looked at the Mental Health Act paperwork for patients and found it to be accurate and complete in all sections.
- Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS).
- Wards had examples of restrictive practices such as kitchens being locked and reliant on staff for hot drinks on Berkley close. On Althorp ward sweets were not allowed and the times for hot drinks were restricted.
- Blanket restrictions were also seen on the CAMHS units, for example on one ward 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.
- Independent advocacy services were available to all patients.
- 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.
- There remain issues around mixed gender accommodation on some older adults wards.
- Patients told us that they felt the wards could be cleaner and the furniture in places was damaged and not replaced.
- 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.
- We found that 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.
- Each ward had a book dedicated to learning from incidents and complaints generated across the hospital site. This ensured learning not just from their own ward but from other services. We saw action plans arising from complaints and the resultant changes on the wards.
- We found that the space on the older adults wards was a challenge to make feel homely, however we saw they had utilised the ends of corridors to create small areas of interest
- Learning disability wards were part of the overall deregation project and were not suitable to meet patient's needs, for example they were not accessible for patients with significant physical disabilities or requiring wheelchair access.
- In the learning disability services significant blanket restrictions were seen for example cigarette breaks were taken hourly, drinks were at set times, access to bedrooms were restricted and no access to kitchens or sensory rooms unless accompanied by an occupational therapist.

Summary of findings

- Some staff in the learning disability services told us that there was little engagement with senior managers or the organisations values and they did not feel able to engage with the wider organisational systems.
- The ward managers in the older adult's service told us they felt supported in their roles and had excellent support from the directors of the service.
- The PICU hospital director offered regular open clinical between 7pm and 9pm which were open for staff to attend.
- There were recognised difficulties in the learning disability services in ensuring that the wards had the correct staff skill mix for the patient's needs. There were regularly high numbers of bank and agency staff used across these wards.
- We saw that staff in the neuropsychiatry services and PICU were using tablet computers to monitor outcome measures electronically while on the ward which meant that they saved time by not returning to the desktop computer and logging into the electronic note system.
- The PICU ward was affiliated to the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU). This is an organisation which is involved in promoting and developing work within the PICU settings.
- Hawkins and Makeness wards had recently participated in the overall William Wake House "self" and "peer review" parts of the quality network assessment for forensic mental health services.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires Improvement

Safe and clean ward environments

- The design and layout of some wards made lines of sight difficult.
- We found ligature risk and environment audits were undertaken every six months. The clinic rooms were fully equipped and resuscitation equipment was checked regularly and recorded.
- There were ligature audits throughout the service which were undertaken annually. We saw that some ligature risks had been identified and there were contingency plans in place to manage these.
- The wards of the male forensic service were generally unclean.
- Not all wards had a seclusion facility available for use. Grafton and Hereward Wake wards did not have a seclusion room. On Hereward Wake, this meant that a patient requiring seclusion was being transported to a different location by secure transport. We heard on rare occasions the transport was unavailable leaving both the staff and patient at risk.
- Althorp ward and Tallis ward had identified environmental blind spots which were managed by increased staff observation and awareness.
- We found that seclusion facilities on the PICU and the CAMHS units were free of ligature points and allowed observations from nursing staff in an adjoining room to be made safely.
- We were told when seclusion facilities on Ferguson Ward were in use, the wards accessed Sherwood Ward seclusion facilities. We were concerned about the safety of moving people in a restraint situation, either downstairs or using a lift, which we were told was unreliable and had broken down several times.
- 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

Safe Staffing

- A staffing tool was used to calculate the correct staffing ratios to ensure patient safety and we saw the numbers had been maintained including at least one qualified and experience nurse at all times on the older adults service.

Summary of findings

- We were told that some agency staff and some bureau staff did not have access to the electronic notes system meaning that patient information would not be readily available in an emergency.
- Patients told us that the CAMHS service were insufficiently staffed which meant that they were not always able to have their granted leave. Managers agreed that at times it was difficult to ensure the safety of the ward, whilst meeting the needs of the patients.
- Patients told us that due to high levels of bank and agency staff who did not know them caused them to be cared for and treated differently.
- Some staff and patients told us that they did not feel safe on the learning disability wards.
- We saw minutes from the men's service patient safety meeting, which acknowledged that staffing was a contributory factor in the learning disability service for an increase in incidents.
- Staffing levels were adapted when changes in peoples need were identified.
- We saw rotas which showed the wards were regularly using bank or agency staff, Mackaness had three members or regular staff on duty and six agency staff on the day of our visit.
- Fairbairn Ward management informed us the electronic system did not allow them to specify staff trained in British Sign Language. This meant patients were not always able to communicate effectively with staff to make their needs known.

Assessing and managing risk to patients and staff

- The care records we looked at evidenced that risk assessments were clear reflected the needs of patients and were up to date.
- We found that some ward practices were restrictive for example young people were all searched on their return from unescorted leave.
- The seclusion policy was followed correctly, however on Sitwell Ward we found that post seclusion reviews were not consistently documented.
- Staff received training in de-escalation skills and conflict resolution.
- We found that in the CAMHS service prone restraint was still being used when retraining young people. We also found that risk assessments and Care plans around this restraint were not always in place.
- We found that routine restrictive practices were in place to manage risk, behaviours related to daily care and treatments were measured using generic levels.

Summary of findings

- Ward staff were able to adequately describe the observation policy and how such observations could be increased or decreased.
- We found that the seclusion facility on some learning disability wards were used for “time out” and patients would go voluntarily to the seclusion room for this. This is in contradiction to St Andrew’s seclusion policy.
- On the learning disability ward some staff did not know the safeguarding process or where they could find out about current ward issues.
- Some staff did not demonstrate understanding about appropriate use of seclusion facilities in the learning disability services.
- On Seacole Ward, there were errors in the recording of medication administration.
- Sitwell ward was not consistently documenting patients review of restraint
- Sitwell ward was not following St Andrew’s Seclusion policy with regard seclusion reviews with patients.

Reporting incidents and learning when things go wrong

- Staff throughout the organisation were aware of how to report incidents and we saw good examples of staff learning from the investigation of adverse events.
- The majority of staff were aware of the safeguarding procedures and told us that they would have no hesitation in escalating concerns to their managers.
- 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.
- We found that the CQC had not been sent notifications relating to incidents affecting the service or the people who use it within the learning disability service.

Are services effective?

Good

Assessment of needs and planning of care

- Every patient had a full assessment of their needs.
- We found in the older adults services that care plans were detailed, personalised and accurate to the care we observed being provided.
- We saw care plans relating to physical health which included liaison with the onsite GP services.
- We saw good use of the “my shared pathway” which embedded patients involvement and voice in the care planning process.

- None of the patients in the CAMHS service had a health action plan in place.
- We found that the CAMHS service were using the safety risk management system as used elsewhere in the hospital and they were not child focused.
- We found in the learning disability service some care plans were generic and not person centred, in particular the risk safety system.
- We found that on the CAMHS rehabilitation ward that there was a general lack of discharge planning.
- Patient's views from those in the Northampton Men's service were not consistently involved in the planning of their care and treatment.

Best Practice in treatment and care

- The medication records demonstrated adherence to professional guidance including the British National Formulary and the Nursing and Midwifery Council's standards for medication management.
- Staff used a nationally recognised Health of the Nation Outcome Scales (HoNOS) rating scale to measure patient's recovery.
- During our inspection, we witnessed audits being undertaken including infection control, medication records and clinic room equipment.
- In Spring Hill house the ward had established a treatment programme based on Dialectical Behavioural Therapy (DBT).
- Staff working in the neuropsychiatry services had an understanding of current NICE guidelines.
- The neuropsychiatry services used positive behavioural therapy for the rehabilitation of patients with acquired brain injury.
- The programme of support and therapy on Tallis Ward was not as well developed for those patients who had Huntingdon's disease and staff felt less comfortable working with this patient group.
- Nursing and support staff we spoke with in the CAMHS services did not have any understanding of positive behaviour support.
- There did not appear to be an opportunity for patients to appeal against decisions made about their risk levels, or clear individual behaviour markers and goals for changes in levels.
- Learning disability patients told us that the restrictions around the risk safety system made them angry.
- We found that the risk based safety system is being used to manage non risk behaviours such as non-engagement.

Skilled staff to deliver care

- On the older adult wards staff received supervision on a monthly basis in addition to a weekly reflective practice session facilitated by the psychologist.
- Appraisal of performance was undertaken annually.
- We were told that there were issues around maintaining staff on Fairburn ward who were trained in British sign language (BSL). It often occurred that staff were trained up to a level to work with patients, then moved to work on other wards.
- We found that staff on the neuropsychiatry wards staff received monthly supervision which was recorded and audited.
- The hospital had access to a GP services as well as a practice nurse and advanced nurse practitioner, as well as podiatry and dentistry services.
- Staff stated that that the training offered by St Andrew's was excellent.
- There were monitoring systems in place to record when staff attended training. Staff told us that they were not always able to be released from the wards to do so.

Multi-disciplinary and inter-agency working

- 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.
- Ward teams had weekly MDT meetings.
- We saw evidence of strong interdisciplinary working on Tallis ward. Handover took place between shifts, however this was verbally and this information was not recorded.
- In the learning disability services there was not a clear and effective system for comprehensive handovers between nursing staff due to the set nursing shifts.
- In the learning disability service there was a daily multi-disciplinary handover Monday to Friday.

Adherence to MHA and the MHA Code of Practice

- We looked at the Mental Health Act paperwork for patients and found it to be accurate and complete in all sections.
- There were some issues about frequency of patients being read their rights on Fairbairn and Rose ward.
- We found on Tavener ward that informal patients were asked to sign a contract for granted leave, which does not reflect the Mental Health Act.
- Patients on the PICU did not have access to a lockable space in their bedrooms and they did not always have their room key.

Good Practice in applying the MCA

Summary of findings

- Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS).
- Most patients were detained under the mental health Act. However other patients were subject to a DoLS order. The proper process had been followed and paperwork was completed accurately with review dates set as required.
- Tallis ward had capacity assessments related to specific issues.

Are services caring?

Good

Kindness, dignity, respect and support

- During our visit, we witnessed several occasions where staff responded to patient's distress and they did so discreetly and appeared to be always mindful of the patient's dignity.
- 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 staff's caring attitude despite the challenges they faced on a daily basis.
- Information on the older adults wards on the boards was in different languages and an interpreter service was available.
- Regular staff were able to articulate individual patients preferences and daily needs.
- On the learning disability wards we observed little interaction between staff with the exception of Bradlaugh and Harlestone ward.
- Staff in the learning disability services expressed concern that the restrictive routines that were in place affected how they were able to care for people individually.

The Involvement of people in the care they receive

- On admission, patients received an information pack about the ward which included pictures to assist them to understand the content.
- We saw patient's views were included in care plans and this included relatives where appropriate.
- "My shared pathway" approach was used in services.
- Patients we spoke with told us that they had been asked about their views and been involved in planning their care.
- The mens forensic services were not constantly documenting patients views in their records or what attempts had been made to engage patients in the process.
- Community meetings were held weekly services where patients could raise issues related to the ward, minutes were available for us to view.

Summary of findings

- In the PICU patients received copies of their care plans and weekly meeting took place where patients attended to update their care plans to ensure involvement.
- One CAMHS ward had developed with the patients around the admission process, complaints and access to advocacy.
- There was little evidence that patients or their carers were actively involved in writing or reviewing their care plans on the learning disability wards. Most patients did not have a copy of their care plan or knew what their goals were. Those that did have care plans on Bradlaugh found that it was not in accessible format.
- Independent advocacy services were available to all patients.

Are services responsive to people's needs?

Good

Access, discharge and bed management

- We saw discharge planning began soon after admission in the older adults service and a strong connection was maintained with the patient's professional team in their home area.
- We saw that all patients had a discharge plan except those on Cranford and Robinson wards. However, there were sometimes delays in discharges when patients moved back to their home areas due to the availability 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.
- We found that 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.
- Pathway bed management meetings took place weekly in the learning disability services and these were minuted.

The ward environment optimises recovery, comfort and dignity

- We found that the space on the older adults wards was a challenge to make feel homely, however we saw they had utilised the ends of corridors to create small areas of interest
- Section 16.9 of the Mental Health Act Code of Practice speaks about gender separation. Prior to our inspection, an issue on Compton Ward had been highlighted to us. We investigated this in depth during our visit and found robust assessments had been undertaken around the decision to place this patient in

that particular area. The hospital directors and ward management team reviewed this situation again during our visit and the patient was moved to another bedroom on the ward.
- There remain issues around mixed gender accommodation on some older adults wards.
- Patients told us that they felt the wards could be cleaner and the furniture in places was damaged and not replaced.
- On Althorp and Berkley Close there were no couches available in the clinic room, patients had to be therefore examined when required in their bedrooms.
- All CAMHS wards had private telephone facilities.
- Hawkins Harlestone and Mackaness wards were newer facilities, which met low and medium secure standards. These facilities were single sex and adhered to safety, dignity and single sex guidance.
- Learning disability wards were part of the overall deregation project and were not suitable to meet patient's needs, for example they were not accessible for patients with significant physical disabilities or requiring wheelchair access.

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Ward policies and procedures minimise restrictions

- Patient's bedrooms had been personalised with their own furniture, belongings and photographs.
- Blanket restrictions were in evidence in all forensic services, such as no patient internet access and access to bedrooms being restricted during the day.
- Wards had examples of restrictive practices such as kitchens being locked and reliant on staff for hot drinks on Berkley close. On Althorp ward sweets were not allowed and the times for hot drinks were restricted.
- Blanket restrictions were also seen on the CAMHS units, for example on one ward 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.
- On the PICU there were times when access to bedrooms were restricted, staff stated this was because of staffing levels.
- In the learning disability services significant blanket restrictions were seen for example cigarette breaks were taken hourly, drinks were at set times, access to bedrooms were restricted and no access to kitchens or sensory rooms unless accompanied by an occupational therapist.

- Most patients on the learning disability services were detained under the mental health act, however we noted that section 17 leave arrangements were linked to the overall generic risk safety system.

Meeting the needs of all people who use the service

- The information boards displayed details of how to access information in a variety of languages including how to access a sign language interpreter. Information was also available in an "easy read" format with pictures to assist understanding.
- We also noted in personal care records respect for cultural preferences for the gender of staff providing care.
- We saw that patients had access to advocacy and chaplaincy services.
- Interpreters (including British sign language) were available for patients.
- Learning disability wards had speech and language therapists, educational support, advocacy and occupational therapy staff to support staff and patients in communication, however we saw limited examples of patient forms and information that were clear and in an easy to read format.

Listening to and learning from concerns and complaints

- Each ward had a book dedicated to learning from incidents and complaints generated across the hospital site. This ensured learning not just from their own ward but from other services. We saw action plans arising from complaints and the resultant changes on the wards.
- Wards had information on display about how to make complaints, although we did not observe easy read information displayed on the learning disability wards.
- We saw that there was a central complaints policy.
- Young people in the CAMHS services stated that they knew how to make complaints but often felt they were not listened to, including complaints about bullying.
- Patients on the learning disability wards told us that they did not feel that they did not feel that their complaints were always listened to or acted upon. Patients told us they did not always get feedback from their complaints.
- We were told that complaints received on the learning disability wards were discussed in ward manager and patient safety meetings. Complaints that were upheld were subject to an independent investigation. All complaints are reviewed for

learning these are discussed at the community, ward, service meetings, are included in the Quality Dashboard and form part of the reporting directly into the executive team on a weekly basis.

Are services well-led?

Good

Vision and Values

- The older adult service management team were motivated toward providing the best practice and high quality care which clearly filtered through to their staff at every level of seniority.
- We were told that staff would probably recognise the new chief executive but would be less likely to be able to describe his role or any of the other members of the organisation's senior directors.
- CAMHS service staff told us they were aware of senior management, but told us they felt underappreciated by those managers and not listened to.
- Some staff in the learning disability services told us that there was little engagement with senior managers or the organisations values and they did not feel able to engage with the wider organisational systems.

Good Governance

- The ward managers in the older adult's service told us they felt supported in their roles and had excellent support from the directors of the service.
- We found that there appeared to be a disconnect between the service auditing and the organisation's department. There were systems in place to ensure learning from incidents and complaints from across the wider organisation as well as in the service itself.
- We were told of lessons learnt meetings following incidents and this information was fed back at ward level.
- Staff in the neuropsychiatry services told us they felt supported by the hospital director and the clinical director.
- Risk registers were available in the neuro psychiatry wards and managers within the service had a good understanding of where the risks lay. Plans were in place to address these.
- The PICU hospital director offered regular open clinical between 7pm and 9pm which were open for staff to attend.
- There were recognised difficulties in the learning disability services in ensuring that the wards had the correct staff skill mix for the patient's needs. There were regularly high numbers of bank and agency staff used across these wards.

- Incident reporting and safeguarding processes were consistent across the wards.

Leadership, morale and staff engagement

- The senior management across the older adult's service demonstrated a strong sense of leadership which staff told us they appreciated.
- Sickness and absence rates in the older adult's service were low in comparison with the rest of the organisation and staff told us they felt able to raise any concerns without the fear of reprisal.
- Staff did express concern about the recent changes in management and said they hoped that the managers now would remain in post as they felt this had affected staff morale in the recent past.
- Wards in the forensic services spoke highly of the multi-disciplinary team.
- Some staff in forensic services were concerned about the long term impact of the derogation project.
- We received positive feedback about the Hospital director in the neuropsychiatry service.
- Staff in the CAMHS service told us they felt able to raise and concerns with their ward managers, but they were unable to do this with more senior managers.
- Staff in the learning disability service told us that they felt stressed and did not feel valued or supported. Staff told us it was difficult working with high numbers of bank and agency staff in very challenging environments.
- We found that staff morale and team performance in the learning disability service had been negatively affected over the past year.

Commitment to quality improvement and innovation

- We saw the older adults service had an audit calendar to ensure care was being monitored effectively. The ward was participating in a number of projects designed to improve patient experiences and quality of care. For example, the Daisy group which was set up to examine published guidance from the National Institute for Health and Care Excellence and other leading bodies.
- The service used a programme called Dementia Care Mapping (DCM). This was an observational tool used in care settings to look at quality of life from the viewpoint of the patient. The service was working with the University of Bradford Dementia Group who were in the process of developing a similar project.

Summary of findings

- We saw that staff in the neuropsychiatry services and PICU were using tablet computers to monitor outcome measures electronically while on the ward which meant that they saved time by not returning to the desktop computer and logging into the electronic note system.
- The PICU ward was affiliated to the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU). This is an organisation which is involved in promoting and developing work within the PICU settings.
- Hawkins and Makeness wards had recently participated in the overall William Wake House “self” and “peer review” parts of the quality network assessment for forensic mental health services.

Summary of findings

What we found about each of the main services at this location

Psychiatric intensive care units and health-based places of safety

Good

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

Long stay/forensic/secure services

Requires Improvement

- Patient's views were not always documented in care plans
- On Fairbairn ward there were not always staff available who were trained in British Sign Language.
- Patient reviews of restraint and seclusion were not always being undertaken and documented fully
- Not all of patients are assisted to understand their rights
- Not all medication administration is accurately recorded.
- All paperwork was of high standard including that for the Mental Health Act.
- Reviews of care within the multi-disciplinary team were thorough and capacity was assessed regularly.
- Within in the Women's service, the documentation of restraint and seclusion was detailed with timings and we saw learning from incidents had occurred

Child and adolescent mental health services

Requires Improvement

- There was a need to assess and treat patients based on individual risk and identified needs, rather than placing emphasis on generic, restrictive risk management processes.
- Agency and bank staff did not have adequate information about individual patient care and any safeguarding protection plans on the wards where they are working.
- The complaints process was not always clearly displayed on the wards in formats people can understand.

Summary of findings

- Feedback from the outcome of complaints was not shared with the complainant on all occasions.
- Seclusion facilities were being used for de-escalation and time out.

Services for older people

Good

- People's individual needs were assessed and detailed care plans formulated to meet these. Care provision was reviewed by the multi-disciplinary team on a weekly basis.
- Communication between staff was clear and complete including learning from incidents both within the service and from the wider organisation.
- Mental Health Act paperwork and consent to treatment documentation was accurate and the proper procedures had been followed in all records we reviewed.
- Patients had undergone initial capacity assessments which were reviewed regularly including assessments for specific tasks relating to their care.
- The Deprivation of Liberties Safeguards process had been followed correctly for those patients to whom it related.
- Practice incorporated latest research and evidenced-based guidance to ensure the most effective care was being provided.

Services for people with learning disabilities or autism

Requires Improvement

- The information about the complaints process was not clearly displayed on the wards in formats people can understand.
- Agency and bank staff did not always have adequate information about individual patient care.
- Seclusion facilities were being used for de-escalation and time out.
- Not all of the staff could demonstrate an understanding about appropriate use of the seclusion facilities.
- The CQC have not been sent notifications relating to incidents affecting service or the people who use it, in line with requirements.
- 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. The provider must ensure that lifesaving equipment is available without delay.

Other specialist services inspected

Neuropsychiatry

Good

- Strong multidisciplinary work on the wards which promoted holistic assessment and treatment of people's needs.
- Use of specifically developed outcome measures for people with brain injuries which informed the treatment plans and therapies used in the service.

Summary of findings

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

Summary of findings

What people who use the location say

We spoke with people who used these services provided by this provider through focus groups, attendance at community meetings, service user forum meetings and individual conversations with people. We reviewed the provider's quality monitoring systems such as surveys and monthly business continuity meeting minutes.

Most people told the inspection teams that staff were caring and understood them and they 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 people told us that the food provided was good. Food was prepared on site and people could choose from a menu.

Some patients felt angry and frustrated by how they are treated, stating that staff do not listen to them and were rude to them.

Patients told us that the restrictions from the overarching risk safety system made them feel frustrated and angry.

Some Carers 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.

Areas for improvement

Action the provider MUST take to improve

Forensic services

- The service must ensure that patient's views are documented in care plans
- Fairbairn ward must ensure that there are enough suitably skilled staff retained on the ward to ensure communication between staff and patients. This includes the ability to request staff trained in British Sign Language.
- Sitwell ward must ensure patients reviews of restraint and seclusion are undertaken and documented fully
- Fairbairn and Rose wards must ensure patients are assisted to understand their rights
- Seacole ward must ensure that medication administration is accurately recorded.

CAMHS

- The provider must ensure that the service has a system in place to learn from incidents and ensure that the risk of harm is minimised.
- The provider must ensure that Care plans and risk assessments are improved to ensure people received care which is appropriate, safe and effective.
- The provider must ensure that managers and staff have knowledge in children's rights, to ensure care is planned in accordance with this.
- The provider must ensure that the service wide risk safety management system is adapted to ensure it meets with the specific needs of children.
- The provider must assess and treat patients based on individual risk and identified needs, rather than placing emphasis on generic, restrictive risk management processes, which are not in line with current Department of Health guidance.
- The provider must improve care planning in relation to restraint and ensure that best practices are followed.
- The provider must ensure the service is following best practices by embedding positive behavioural support as a value and also ensuring where appropriate people have relevant support plans in place.
- The provider must ensure that agency and bank staff have adequate information about individual patient care and any safeguarding protection plans on the wards where they are working.
- The provider must ensure that information about the complaints process is clearly displayed on the wards in formats people can understand.

Summary of findings

- The provider must improve how patient complaints are resolved and feedback given to the patient.
- The provider must ensure that independent investigations are undertaken if complaints are `upheld`. They should also review the process to ensure potential themes resulting from complaints that were "not upheld" are reviewed.
- The provider must review and stop the use of seclusion facilities for de-escalation and time out.
- The provider must ensure staff have training and understanding about safeguarding

Learning Disabilities and Autism

- The provider must ensure that information about the complaints process is clearly displayed on the wards in formats people can understand.
- The provider must improve how patient complaints are resolved and feedback given to the patient.
- The provider must ensure that independent investigations are undertaken if complaints are `upheld`. They should also review the process to ensure potential themes resulting from complaints that were "not upheld" are reviewed.
- The provider must ensure that all staff have training and understanding about safeguarding.
- The provider must ensure that agency and bank staff have adequate information about individual patient care.
- The provider must review and stop the use of seclusion facilities for de-escalation and time out.
- The provider must ensure that the CQC have been sent notifications relating to incidents affecting service or the people who use it, in line with requirements.
- The provider must ensure that care plans and risk assessments are improved to ensure people received care which is appropriate, safe and effective.
- 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. The provider must ensure that lifesaving equipment is available without delay.
- The provider must ensure that risks, benefits and alternative options of care and treatment are discussed and explained in a way that the person who uses the service understands.
- The provider must ensure that all staff can demonstrate understanding about appropriate use of the seclusion facilities.
- The provider must ensure that staffing arrangements having an impact on patients accessing activities, outside space and their leave arrangements are minimised.
- The provider must assess and treat patients based on individual risk and identified needs, rather than placing 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.
- The provider must ensure that all staff demonstrate understanding about appropriate use of seclusion facilities
- The provider must ensure that there are enough members of suitably skilled and experienced staff to care for people safely
- Set `A` and `B` nursing teams and 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. The provider must ensure that these inconsistencies, conflict and poor handover discussions are minimised.
- The provider should ensure that all staff are aware of audits undertaken and are able to give examples of outcomes which affect their ward areas, in order to evaluate and improve the quality of services provided.
- Staff from all disciplines raised concern regarding most of the governance, care and treatment processes being centrally administrated. Some staff told us they did not think that there was enough flexibility to work differently with different patient groups or individuals. The provider must ensure that this process is reviewed to ensure that all care and treatment is patient centred and relevant to the patient group rather than being centrally administrated.

Action the provider SHOULD take to improve

Neuropsychiatry

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

Summary of findings

- The provider should ensure that a review takes place of the mix of patients on Tallis ward where people with Huntington's disease were placed with people with acquired brain injury and ensure the skill mix of staff meets the needs of patients on Tallis ward.
- The provider should ensure that specific training is offered in services where it is relevant. For example, around epilepsy and Huntington's disease.
- The provider should ensure that people who were not detained under the Mental Health Act (1983) and remain informal should have access to leave without conditions

PICU

- The provider should review the effectiveness of their current staff recruitment and retention policy and procedures.
- The provider should ensure that all staff have appropriate access to those electronic care and treatment records that they require to effectively do their job.
- The provider should ensure that records of general observations and 15 minute observations on Sherwood ward are accurate and complete where they are necessary.
- The provider should ensure that a written record of all staff handovers is kept on Sherwood ward.
- The provider should review the current practice of blanket restrictions within this core service. For example the locking of patient bedroom corridors at specific times.
- The provider should review the systems in place on Frinton ward for staff to respond to and meet people's diverse cultural and language needs.
- The provider should ensure that recruitment takes place to ensure that the ward manager for Frinton ward was solely managing that unit.
- The provider should ensure that every action plan detailing their response to direct people's feedback is available on the unit

Learning Disabilities and Autism

- The provider should engage with staff to understand why morale is low and people are leaving substantive posts.
- The provider should review patients long term placement options who have been in extra care facilities for prolonged periods of time
- The provider should ensure that access to seclusion facilities are safe
- The Provider should insure that information is provided in formats that people understand, clearly displaying information about complaints and external agencies, such as the Citizens Advice bureau and CQC.
- The provider should promote better involvement of patients and their carers/family in writing and agreeing care plans and risk assessments and ensuring people have copies of these.

CAMHS

- The provider should ensure that the risks, benefits and alternative options of care and treatment are discussed and explained in a way that the person who uses the service understands.
- The provider should promote better involvement of patients and their carers/family in writing and agreeing care plans and risk assessments and ensuring people have copies of these.
- The provider should consider ways of re-structuring set nursing teams and shifts, in order to enable a comprehensive handover and nursing discussion and reduce the reported inconsistencies and conflict between set teams.
- The provider should address the impact that staffing arrangements are having on patients accessing activities, outside space and leave arrangements.
- The provider should engage with staff to understand how policies and procedures can be adapted to meet the needs of the CAHMS services.

The provider should review patient's long term placement options who have been in extra care facilities for prolonged periods of time

Good practice

Older Persons service

Summary of findings

- People's individual needs were assessed and detailed care plans formulated to meet these. Care provision was reviewed by the multi-disciplinary team on a weekly basis.
- Communication between staff was clear and complete including learning from incidents both within the service and from the wider organisation.
- Mental Health Act paperwork and consent to treatment documentation was accurate and the proper procedures had been followed in all records we reviewed.
- Patients had undergone initial capacity assessments which were reviewed regularly including assessments for specific tasks relating to their care.
- The Deprivation of Liberties Safeguards process had been followed correctly for those patients to whom it related.
- Practice incorporated latest research and evidenced-based guidance to ensure the most effective care was being provided.

Forensic

- Staff across the service showed knowledge of the patient's needs.
- All paperwork was of high standard including that for the Mental Health Act.
- Reviews of care within the multi-disciplinary team were thorough and capacity was assessed regularly.
- Within in the Women's service, the documentation of restraint and seclusion was detailed with timings and we saw learning from incidents had occurred

Neuropsychiatry

- Strong multidisciplinary work on the wards which promoted holistic assessment and treatment of people's needs.
- Use of specifically developed outcome measures for people with brain injuries which informed the treatment plans and therapies used in the service.
- Introduction of technologies on the ward such as tablet computers to improve the patient and staff experience.
- A strong model for future plans of the service meant that at a strategic level it was clear where the development would lie
- There were strong internal governance systems within the neuropsychiatry service which meant that managers within the service had a good understanding of the challenges and strengths within the service they were responsible for.
- People on Tallis ward had been encouraged to write advanced statements and plan their future care should they lose capacity to make decisions regarding their care in the future.

PICU

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

Learning disability

- cohesive multi-disciplinary teams on each ward, who seem to work together effectively, with a strong emphasis on occupational and psychological therapies

St Andrew's Healthcare - Men's, Adolescent, Neuropsychiatry and Women's service.

Detailed findings

Services we looked at:
Psychiatric intensive care units; Long stay/forensic/secure services; Child and adolescent mental health services; Services for older people; Services for people with learning disabilities or autism; Other specialist services inspected

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Chair: Stephen Firn CEO Oxleas NHS Foundation Trust

Team Leader: Nicholas Smith Head of Hospital Inspection CQC

The team included CQC inspectors and a variety of specialist including a CQC clinical national advisor for people with learning disabilities, CQC mental health act reviewer, speech and language therapist, nurse, consultant psychiatrists, a health and well-being practitioner, a specialist CQC pharmacy inspector, occupational therapists, advocate, expert by experience and their carers.

Background to St Andrew's Healthcare - Men's, Adolescent, Neuropsychiatry and Women's service.

St Andrew's is the UK's leading charity providing specialist NHS care. The provider has been in existence for 176 years.With over 1000 inpatient places, the provider has the UK's leading national secure facilities for adolescents and young adults, women, men and elders, in addition to community and in-reach services, private therapy services for GP-referred patients and medico-legal expertise. The charity's national and regional services in Northampton, Essex, Birmingham and Nottinghamshire make St Andrew's

by far the largest provider of care in this sector.These four sites have in-depth expertise in trauma, personality disorder, psychosis, autism, learning disability, brain injury and dementia.

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

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of independent health care providers of mental health services. This provider was selected to enable the Care Quality Commission to test and evaluate its new inspection methodology across a range of different mental healthcare service providers.

How we carried out this inspection

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

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

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

We carried out announced visits to these units between 09 and 11 September 2014 and a further unannounced visit on the 24 and 25th September.

We held focus groups with people who were using the service, senior staff and junior staff.

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

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

Good

Psychiatric intensive care units and health-based places of safety

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

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

Summary of findings

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

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

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

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

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

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

Good

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units safe?

Good

Safe and clean ward environment

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

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

Safe staffing

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

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

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

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

Assessing and managing risk to patients

The provider had a system for ensuring that people had risk assessments following admission and regular updates such as the evidence based tool developed by the Institute of Psychiatry, 'threshold assessment grid' risk screening tool, (TAG). A recently reviewed risk monitoring system was also in place which detailed, for example the access people could have to items in their room and to Section 17 leave off the ward. People's risk level was reviewed and detailed in daily notes.

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

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

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

Staff were aware of safeguarding procedures and had undertaken mandatory training covering safeguarding issues. There was a social worker based on the ward who

Good

Psychiatric intensive care units and health-based places of safety

took the lead for the ward on safeguarding. The ward had a "lessons learnt" folder on the ward. However, we saw that few staff had signed the information in this folder to evidence that they had read it. This meant that there was a risk that information was provided but that staff did not read it.

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

Reporting incidents and learning when things go wrong

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

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

Are psychiatric intensive care units effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

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

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

Best practice in care and treatment

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

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

Skilled staff to deliver care

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

All staff had access to regular supervision and staff had had annual appraisals. We saw that supervision records were up to date. Medical staff had regular peer review meetings monthly to develop clinical role. Staff were aware of the observation policies on the ward. However, while information about people who were on constant

Good

Psychiatric intensive care units and health-based places of safety

observations was comprehensively recorded, the records for people on 15 minute observations and general observations were not complete. Staff were able to explain when patients were subject to searches.

Multi-disciplinary and inter-agency working

There was a multi-disciplinary team on the ward which met weekly. We observed a 'clinical team meeting' on the ward. We saw that the professions present were involved and used their expertise to inform their colleagues. The ward divided into different shifts with staff working 'long days and nights'. Handovers between shifts were not recorded which meant that there was a risk that some information may not be shared. When staff needed to link with local teams they did so to ensure that information on admission and discharge was shared. The social worker on the ward liaised with local services and ensured that the relevant information was passed on to local services when people were discharged.

Adherence to the MHA and the MHA Code of Practice

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

The ward had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act code of practice. Advocates were available to people on the ward and most people we spoke with told us they were aware of their rights. People on the ward did not have access to specific lockable space and they did not have keys to their bedrooms.

Good practice in applying the MCA

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

Are psychiatric intensive care units caring?

Good

Kindness, dignity, respect and support

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

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

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

The involvement of people in the care they receive

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

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

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

Are psychiatric intensive care units responsive to people's needs?

(for example, to feedback?)

Good

Access, discharge, and bed management

People were referred to the ward from within the organisation and externally. Discussions were held on the

Good

Psychiatric intensive care units and health-based places of safety

ward with the clinical team regarding the appropriateness of referral. The management within the hospital wide service also reviewed admissions and delayed discharges from the ward through a regular meeting. We found that people had discharge plans.

The ward environment optimises recovery, comfort and dignity

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

There was access to outdoor space. The ward also had rooms where activities took place, including a gym area. People told us that they were satisfied with the meals which they received. We saw that information was available on the ward about activities and services which were available locally.

Ward policies and procedures minimise restrictions

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

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

Meeting the needs of all people who use the service

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

Listening to and learning from concerns and complaints

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

The ward retained information about complaints on the ward. However, only formal complaints were logged and there was not accessible and immediately available information about the conclusion of complaints which had been made on the ward. We did not see not a robust system of feedback to people regarding any informal complaints that they might have made. This meant that there was a risk that learning from local complaints was not embedded at ward level.

Are psychiatric intensive care units well-led?

Good

Vision and values

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

Good governance

We spoke with staff on the ward and the lead nurse for the men's services within the mental health pathway which included the PICU ward at Northampton. They explained

that information received from incident reporting is fed to senior staff to identify gaps in the service. Reports are generated weekly in relation to incidents including use of restraint and seclusion on the ward. There were specific patient safety groups on a service and charity wide level which ensured that learning was embedded within the organisation.

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

Leadership, morale and staff engagement

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

Commitment to quality improvement and innovation

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

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

Requires improvement

Long stay/forensic/secure services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Information about the service

St Andrew's Healthcare provides care for patients admitted with a mental health needs, and a history of offending or challenging behaviour. Referrals are taken from across the United Kingdom.

During our inspection at the Northampton location we:

- Spoke with 52 staff.
- Spoke with 36 patients.
- Looked at 52 sets of patient records along with the associated Mental Health Act paperwork.
- Reviewed 78 medication records and consent to treatment documentation.
- Attended a number of care meetings, multi-disciplinary meetings and community meetings.

Summary of findings

We found that the design and layout of some wards made lines of sight difficult and some blind sports were found in seclusion rooms and bedrooms.

Ligature risk and environment audits were undertaken every six months. The clinic rooms were fully equipped. However we found variable practices when it came to checking and recording of resuscitation equipment. Some of the equipment was not checked with the frequency that it should have been.

Staff undertook an audit of ligature points once a year. These had identified some ligature risks and there were contingency plans in place to manage these.

There were concerns raised across the forensic services around staffing levels. We found that whilst there was a recognised tool used for identifying people's dependency needs, Some shifts did not have a sufficient number of nurses to provide high quality care. We were told by staff and patients that these reduced numbers impacted on the patient experience. We found high levels of agency and bureau staff being used. Sometimes the nursing staff did not have the relevant skills needed for the patient groups.

Staff had received safeguarding training and demonstrated that they knew how to protect people from harm.

Staff did not always follow the seclusion policy with regard to seclusion reviews with patients

Requires improvement

Long stay/forensic/secure services

Staff we spoke with had a good understanding of the incident reporting system. The provider used a 'Datix' system to report incidents and there were systems in place for reviewing and learning from these incidents to prevent a reoccurrence.

Patients had well written risk assessments and care plans. Health plans were in place. Care programme approach meetings took place regularly.

Staff assessed outcomes for people through use of the Health of the Nation Outcome Scales (HoNOS) secure assessment tool. We found that a range of therapeutic interventions in line with National Institute Health and Care Excellence (NICE) took place.

We found effective multi-disciplinary working (MDT) within the services to meet people's needs.

We saw clear written procedures in place regarding their use of the Mental Health Act and the Mental Health Act code of practice. We found however that these were not consistently adhered to.

Advocates were available to people throughout the hospitals and most people we spoke with told us that they were aware of their rights.

We saw from patients' records that the provider used the my shared pathway, which is a recovery and outcomes based approach to the planning and delivery of care.

We found blanket restrictions in place on most wards we visited such as no patient internet access and doors being locked during the day.

Most staff were aware of the senior management within the provider. However, some staff told us that they felt there was a disconnect between the executive team and the teams on the wards.

The ward managers had a good understanding of the risks on the wards and within the service this showed that information was shared and learning promoted.

Most staff reported that they felt supported by their manager. They told us they had undertaken training and received supervision. However supervision practices were variable across the four sites. Staff had access to team meetings and had an appraisal to ensure they were competent and confident in their role. Most staff reported managers were approachable and they were effective leaders.

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

Requires improvement

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Safe and clean ward environment

There were some areas within the wards where there was poor visibility. This was managed through staff observations and knowledge of the patients. There were ligature audits throughout the service which were undertaken annually. We saw that some ligature risks had been identified and there were contingency plans in place to manage these within the context of the group of patients on the ward. There were some rooms available which were better adapted to people who were at higher risk of self-harm.

There was a perimeter check of the ward environment on a daily basis and every month bedroom audits were undertaken to ensure that any environmental issues were reported. All the wards of the male service were generally unclean. The wards were hot and felt stuffy. The women's service wards were of a higher standard however patients still told us they wished their surroundings were cleaner.

The clinic rooms where medication was stored were clean. Most wards in the service had resuscitation equipment available and we noted it was monitored regularly. However, Grafton ward's lifesaving equipment was shared with another ward on the same site.

Not all wards had a seclusion facility available for use. Grafton and Hereward Wake wards did not have a seclusion room. On Hereward Wake, this meant that patients requiring seclusion were being transported to a different location by secure transport. We heard on rare occasions, the transport was unavailable leaving both the staff and patient at risk.

Sitwell ward had a seclusion room. This was not available due to the area being used to nurse a patient in long term segregation. Patients requiring seclusion were therefore taken to another ward within the same building. We had concerns about the maintenance of that patient's dignity and the potential distress caused to other patients who may have witnessed this. Indeed, patients told us this was of concern to them.

We had concerns regarding Fairbairn ward's seclusion room. The room was monitored by CCTV. There were areas of the main room and bathroom which remained not visible to staff. There was an intercom system installed which would be of no use for non-hearing staff. The observation window in the door was inadequate for signing as agreed by the organisation. We highlighted these issues to management who met to resolve this during our inspection.

Safe staffing

Staff told us that few agency staff were used and that, when additional staff were needed to carry out observations, these staff were provided from the bureau. We were told that agency staff and some bureau staff did not have access to the electronic notes system.

There were always qualified staff on duty, a range of allied health professionals and medical staff. At night across the whole site there are permanent night staff and on call cover divided by directorate.

Ward managers we spoke with told us they could access extra or replacement staff via the provider's staff bureau via the online management system. They were able to ask for regular staff who knew the ward and patients to enable consistency.

Fairbairn Ward management in Northampton informed us the electronic system used to allocate staff did not allow ward managers to specify that they required staff trained in British Sign Language. This meant patients were not always able to communicate effectively with staff who were allocated to their wards. The provider has clarified that this is possible if the system is used appropriately.

Staff consistently spoke of being understaffed. The rotas did not support this. The numbers were made up to compliment by bank or agency staff. However, we found that over 150 hours of activities had been cancelled in August 2014 stating the reason as lack of staff. This would suggest that the issue lay rather with the deployment and usage of the staff on shift rather than numbers.

Assessing and managing risk to patients and staff

Staff on the ward had a good understanding of the safeguarding audit processes. The care records we looked at showed that risk assessments were clear, reflected the needs of patients and were up to date. We checked the medication and clinic room on the wards and found the

records were up to date and medicines were appropriately recorded and stored. However on Seacole ward, we found errors in recording including a missed signature on a prescription chart.

The seclusion policy had been followed correctly including observation of the patient, medical and nursing reviews and documentation. However, on Sitwell ward we found that post seclusion reviews were not consistently documented as required by the Mental Health Act code of practice.

Some patients were prescribed medication to help with extreme episodes of agitation and anxiety. These medicines were prescribed to be given only when other calming techniques had been used by staff. This is known as rapid tranquillization. Arrangements were in place to provide guidance to medical and nursing staff for this treatment. We found patients were physically checked for their own safety following administration of medicines for rapid tranquillisation.

Reporting incidents and learning from them when things go wrong

Staff we spoke with had a good understanding of the reporting system. The provider used a 'Datix' system to report incidents which ensured that ward managers were aware of all the incidents which were reported. Staff told us they had access to support through debriefing after incidents but this was not always a formal process.

The wards had regular meetings where information was disseminated about incidents both on the ward and across the service. There were incident folder available on the wards in staff areas. Staff who were not able to attend meetings could view these minutes and were asked to sign to ensure that they had read them.

The service had an additional 'lessons learnt' update which was sent to wards within the service to ensure that learning took place across the service and across the provider.

We spoke with the ward manager on Grafton ward who gave us examples of how incidents had led to learning on the ward. For example, one incident where a person on the ward had needed additional support regarding physical healthcare needs had led to an adaptation of intermediate life support (ILS) training to incorporate their specific needs.

All permanent staff we spoke with said they would be confident to report any safeguarding issues. They demonstrated an understanding of the types of situation which would require a formal referral. We reviewed a recent safeguarding incident on Sunley ward which had been reported by ward staff to the local authority and saw the comprehensive investigation. This had concluded the incident was unfounded and no further action was required.

Are long stay/forensic/secure services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

We looked at 47 sets of care records and found each patient had a full assessment of their care needs. Care plans and risk assessments were up to date, reviewed regularly at the team meetings and were recovery focused. These had been personalised for each patient to reflect their individual needs. There were specific care plans for physical health issues including care plans for physical health under restraint where this was indicated. Patients' physical health was assessed regularly and recorded so that any concerns could be monitored and action could be taken if required.

Generally patients had well written risk assessments and care plans. However on the two male specialised wards for patients with hearing difficulties and those with acquired brain injuries(Fairbairn and Rose), the care plans were very long and were not in a format which would assist patients to understand them

Best practice in treatment and care

The medication records demonstrated adherence to professional guidance and we noted referrals had been made to specialist services where required.

These services were able to offer psychological therapies as recommended by NICE and we found the women's service were proactive in engaging patients in treatment.

In Spring Hill house the ward had established a treatment programme based on dialectical behaviour therapy (DBT). We saw evidence which showed how members of the

multi-disciplinary team had conducted and published research into this area. The care pathway for patients here also included access to range of non-secure accommodation as part of their care pathway.

The wards had an activity programme which was supplemented with individual activities for those unable to participate in groups. Staff and patients informed us that activities were often cancelled because of staff were off the ward escorting patients, particularly in the men's service. We looked at the organisation's overall data around cancelled activities and found that, in August 2014, in the men's service over 123 hours of activities had been cancelled due to lack of staff as had 31.5 hours in the women's service. According to the organisations data, over 123.5 hours of 1 to 1 nursing interventions were cancelled in August for the same reason.

The provider had worked with the Royal College of Psychiatrists to adapt the health of the nation outcome scales specifically for service users in secure settings. These were reported to their commissioners in order to meet their contractual obligations.

Skilled staff to deliver care

The ward teams included nursing staff, occupational therapists and a technical instructor, social workers, a consultant and a psychologist. The team on the ward worked effectively together

Staff received mandatory training annually which included safeguarding adults, basic life support training and training to ensure that restraint was applied safely when necessary. Some nursing staff on the wards had received specialist life support training to meet the needs of one patient who had specific physical health care needs. This meant that there was always a member of staff who could provide specific care to this person were they to need it. Qualified nursing staff on the ward received regular monthly supervision and annual appraisals.

Serious concern was expressed to us about the movement of staff between wards. Fairbairn ward is a specialist ward for patients with hearing difficulties. Staff were trained in British Sign Language (BSL) to enable them to communicate effectively with patients. Senior management and medical staff expressed their concern around losing vital skills due to the practice of moving staff around. We were told that having invested time, finance and training into staff to ensure high quality care, they were moved away from the ward without explanation being replaced by staff that had no training in BSL. Patients and staff confirmed this and said they believed quality of care suffered as a result.

People's physical healthcare was monitored regularly and we saw that levels of anti-psychotic medication were monitored to ensure that people's physical health care needs were met. There was a GP and specialist nurse practitioners who covered the Northampton site to whom people had access. People were offered access to smoking cessation support.

Multi-disciplinary and inter-agency team work

The ward team had weekly multidisciplinary meetings to ensure that information between the teams was shared. Staff across the disciplines attended regular ward rounds to discuss the needs of people on the ward.

Staff told us that they liaised with other teams when people were being admitted to the ward and discharged from the ward.

Adherence to the MHA and MCA Code of Practice

We looked at the Mental Health Act paperwork for patients and found it to be accurate and complete in all sections. This meant that patients were not illegally detained or treated. All consent to treatment paperwork was present and correct.

Generally we found that patients were regularly being assisted to understand the rights under the Mental Health Act. However, we found on Fairbairn and Rose wards this was not being consistently recorded. We also found evidence in patient notes of rights being documented as not understood and the next review date being six months ahead. Staff were unable to tell us or describe other methods they might use to assist that patient to gain an understanding of their rights.

Good Practice in applying the MCA

Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). All staff we spoke with were able to tell us in detail how this related to the patients. In reviewing the care records, we found detailed mental capacity assessments relating to different aspects of the patients' life and care provision. These were reviewed at the weekly team meetings.

Requires improvement

Long stay/forensic/secure services

Are long stay/forensic/secure services caring?

Kindness, dignity, respect and support

We observed the engagement between patients and staff on all wards. Staff appeared to interact in a respectful and caring manner. We noted staff knocking on bedroom doors before entering.

However on the male wards, at times the interactions appeared at times to be more functional and reactive to behaviour rather than spontaneous. Six patients told us this was the case and felt that the cause on occasions was the lack of awareness by agency and bureau staff of patients' communication and engagement needs. Regular staff were able to articulate individual patients' preferences and daily needs.

The involvement of people in the care they receive

We saw from patients' records that the provider used the my shared pathway (MSP) approach, which is a recovery and outcomes based approach to the planning and delivery of care. We found differing practice between services. The women's service records showed that people were involved in their care plans and that their views had been included. Patients we spoke with told us they had been asked about their views and had been involved in planning their care.

On Spencer North ward we were invited to attend two care programme approach meetings. Both of these were chaired by the patients. During the meeting the patients' electronic records were displayed and any decisions were clearly explained to the patient.

The men's service was not consistently documenting patient's views in the records or whether attempts had been made to engage people in the process.

Both services were able to evidence involvement of relatives in care review and planning. One relative expressed concern that the efficiency of the care planning process and discharge planning had reduced since the process had become centralised in the organisation. They told us "the organisation was doing good work but the actions don't always happen and communication had slowed down."

There was a regular community meeting held on the wards weekly where people were able to input their views and ideas into the running of the service. The service received input from advocacy services. On Rose ward, patients received an information pack about the ward which included pictures to assist them to understand the content. We saw how this pack was personalised for each person and included information about care reviews, how to complain, the ward activities and names and pictures of their care team.

Are long stay/forensic/secure services responsive to people's needs? (for example, to feedback?)

Access, discharge and bed management

We saw that all patients had a discharge plan except those on Cranford and Robinson wards. We were told there were sometimes delays in discharges when people moved back to their home areas due to the availability of appropriate facilities. There were social workers based on the wards to assist with discharge pathways from the hospital.

On Hereward Wake and Spring Hill house both patients and staff we spoke with told us they were concerned about the impact on care pathways as a result of changes to commissioning arrangements. This would mean when patients were ready for discharge they may not be able to access the local step down facilities as these would no longer be funded.

The ward environment optimises recovery, comfort and dignity

The wards had a range of rooms for providing support and treatment. There were quiet rooms for patients who 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.

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

Requires improvement

Long stay/forensic/secure services

Many wards we visited across the service did not meet NHS England environment standards so were part of the organisation's project to upgrade wards to meet the standards required.

Patients on Grafton ward had moved from a ward where they had had ensuite facilities and outdoor space to ward were they did not have this. 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.

Ward policies and procedures minimise restrictions

Blanket restrictions were in evidence on each ward we visited. These included no patient internet access and bedroom doors being locked during the day There were practices on some wards designed to facilitate patients attending groups such as bedroom doors being locked during activity sessions. If patients requested access to their room during this time, it was not denied them. All care was personalised and any restrictions for individuals were risk assessed, documented and reviewed regularly.

All patients were subject to the Mental Health Act. However we noted signs informing us that any informal patients were able to leave the ward when they wished.

Patients' bedrooms had been personalised with their own belongings and photographs.

Some patients on Grafton ward told us they had limited cigarettes breaks during the day because the ward did not have access to outside space.

Patients had access to a telephone which ensured that private telephone calls could take place.

Meeting the needs of all people who use the service

Most patients we spoke with told us that they felt their needs were met by the services provided on the ward. We saw that people had access to advocacy and chaplaincy services which covered major religions. An interpreter service (including sign language) was available to patients.

On Foster ward there were two Polish patients and we saw the arrangements in place to provide translation services for them at formal meetings and on a daily basis. This was through accessing the provider's translators or utilising Polish speaking staff.

Listening to and learning from concerns and complaints

Information about services on the wards included information about complaints and access to advocates.

Patients we spoke with told us they spoke to the staff if they were unhappy about anything. Several patients told us they waited to speak to regular staff as they questioned the knowledge of the bureau staff.

Fairbairn ward demonstrated learning and change of environment as a result of patient concern. Patients' raised concern for privacy as they were unable to hear staff knocking on their bedroom door. The ward installed a flashing light system into patient's bedrooms to alert them when a member of staff was waiting to enter.

Each ward had a book dedicated to learning from incidents and complaints generated across the hospital site. This ensured learning not just from their own ward but from other services. We saw action plans arising from complaints and the resultant changes on the wards.

Are long stay/forensic/secure services well-led?

Vision and values

Most staff were aware of the senior management within the provider. However, some staff told us that they felt there was a disconnect between the executive team and the teams on the wards. One person told us they felt there had been an improvement with the new chief executive who had been recently appointed.

Some ward staff expressed concern around the bureau staff's knowledge and perceived involvement in the provider's vision. A member of staff told us "bureau staff don't seem to have a sense of involvement in the organisation, most just come do a job and go away again"

Good governance

The service had ward manager meetings weekly. Information in these meetings was collated and fed into meetings at ward level. A divisional quality and compliance meeting met to feedback and ensure learning across the service and this fed into the quality and compliance meetings across the provider. Action plans were sent back to the ward, however there appeared to be technical issues around accessing these on the electronic system. This meant that ward managers could not always access the plans to make the identified changes on the wards.

Requires improvement

Long stay/forensic/secure services

There were separate 'lessons learnt' meetings following incidents and the information from these meetings was fed back to a ward level. These meetings ensured that quality at the ward level was monitored. The ward managers had a good understanding of the risks on the wards and within the service which meant that information was shared and promoted learning.

Leadership, morale and staff engagement

Staff on the wards told us they felt supported by their direct line managers and there was good teamwork and morale on the ward. All ward staff we spoke with spoke highly of the multi-disciplinary teams.

Some staff we spoke with felt they had not been briefed particularly well by the provider about the rationale for the moves and felt this had a negative impact on their morale. We spoke with ward managers and they confirmed they had participated in the planning and decision making process, and told us they had tried to share this information with both patients and staff.

On each ward we visited involved in the services that did not meet NHS England environment standards, staff told us the local leadership was good and they felt there was good team working. However, they were concerned about the longer term impact on team working following the environmental improvement project. Some staff told us they had not been involved in this change process and felt disconnected from it. One member of staff told us that the organisation's senior management were "in a slightly different world".

Commitment to quality improvement and innovation

Information was available at a ward level regarding the quality metrics. Most staff had a good understanding of the performance of the ward within the provider. However, the ward management teams had strong plans focusing on improvement.

Requires improvement

Child and adolescent mental health services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Information about the service

St Andrew's offers medium and low secure specialist services for children with mild/moderate learning disabilities and challenging behaviour, including individuals who may also have a mental health problem and offending history. They also have care pathways and wards specifically for children diagnosed with autistic spectrum disorder (ASD).

The services are located at Northampton. We visited the CAMHS wards located in Northampton, accepting admissions for children with learning disabilities, autism and mental health conditions who meet their criteria.

Bayley ward is a medium secure inpatient ward that can accommodate up to 10 children and adolescents.

Heygate ward is a medium secure inpatient ward that can accommodate up to 10 children and adolescents.

Church ward is a low secure inpatient ward that can accommodate up to 10 children and adolescents.

Fenwick ward is a low secure inpatient ward that can accommodate up to 10 children and adolescents.

John Clare ward is a low secure inpatient ward that can accommodate up to 14 children and adolescents.

Heritage ward is a low secure inpatient ward that can accommodate up to 14 children and adolescents.

Richmond Watson is a low secure inpatient ward that can accommodate up to 12 children and adolescents.

Boardman is a low secure inpatient ward that can accommodate up to 10 children and adolescents.

Elgar ward is a locked inpatient ward that can accommodate up to 16 children and adolescents. Elgar ward is not part of the provider adolescent services. The service provides care for young people with a brain injury ward and is managed by the provider as part of the neuropsychiatry service.

Requires improvement

Child and adolescent mental health services

Summary of findings

We identified that the service required improvements. The CAMHS service used methods of restraint such as "prone restraint". The Department of Health guidance positive and safe: reducing the need for restrictive interventions, has criticised any use of prone restraint. The service equally did not always follow best practices in relation to managing complex behaviours and ensuring people had good access to health monitoring, in accordance with planned reviews of physical, emotional and psychological health.

We found there were some blanket restrictions in place. This was reflected in not only the practices we identified but also from what we were told by senior managers and staff working in the hospital. They recognised some aspects of the service required development and improvement to ensure high quality care was provided consistently to both children and young adults.

We found care plans were not holistic, personalised or recovery focused. Plans we looked at had not been developed with the children, young people or their relatives, carers or advocates. Where professionals such as occupational therapist and psychologists had been involved in assessing people's needs and implementing treatment plans these were not always embedded in the day to day care plans which had been developed by the nursing team.

Many of the policies and procedures in place were hospital wide policies. The CAMHS service had very few policies and procedures which were specific for the CAMHS service. The philosophy of care was not child focused, for example staff we spoke to had limited knowledge and understanding of UN Convention of Childrens Rights and important guidance such as Every Child Matters.

Are child and adolescent mental health services safe?

Requires improvement

Assessment of needs and planning of care

We looked at the care records of 16 people across nine wards and found that's they were not personalised, holistic and recovery focused. Improvements were required.

The service used the support plans "my shared pathway" which is evidenced based practice and each person had a copy of the plan if they wished. People we spoke with told us they were aware of their plan and its contents but did not understand what it was for.

We found there was a range of professionals involved in people's care such as psychologists, occupational therapists, speech and language therapists, psychiatrists and also nursing and support staff that were responsible for the day to day delivery of care.

We identified that each professional would input their reports and recommendations onto each person's case notes but the detailed information provided was not always transferred in the care plans of individuals which meant that there was not always a unified approach to delivering care.

For example where people displayed behaviours such as inappropriate sexualised behaviour there was information in psychology reports which detailed strategies and interventions staff could use to manage people's behaviour. This information was not detailed in the daily care plans staff used to support people. We spoke with nursing staff and they were unable to explain the strategies and interventions identified in the psychology reports which meant they were not reflecting on this information whilst planning and delivering people's care.

We spoke with managers and support staff regarding our findings who acknowledged our concerns. The feedback we received was the system used for reporting and writing care plans is of a complex nature. Nursing staff told us it was often difficult to find the information but accepted daily care plans regarding strategies and interventions could be improved.

Requires improvement

Child and adolescent mental health services

We looked at how people's physical health care needs were managed and found although people had physical examinations when they were needed and were referred to a health professional when required, the service had not followed the Department of Health's Guidance on health action plans. None of the young people with autism or learning disability had a plan in place. A health action plan details the support required so people with learning disabilities and autism can lead healthy lives. It identifies potential health concerns and promotes a positive well-being for the person identifying the emotional and psychological needs of individuals. None of the people residing at St Andrew's benefited from this approach to maintain positive healthy lives despite some people on some wards having a learning disability and/or autism.

Best practice in treatment and care

We looked at the medication practices within the service and found clinicians working in the service had adopted the principles contained with Royal College of Psychiatrists (2007) Challenging Behavior: A unified approach. Clinical and service guidelines college report CR 144 because clear reasoning was detailed regarding the use of antipsychotic medication where people displayed aggressive, violent and disturbed behaviour.

It was also evident that people's medication was continually reviewed and where changes had occurred these had been done within the legal framework. However we did bring to the attention of clinicians one example of where appropriate legal steps had not always been followed in relation to prescribing medication under the Mental health Act 1983 documentation.

We spoke with psychologists working in the service and were told of a range of psychological therapies used to support people with their mental health conditions. For example treatments relating to sexualised behaviour were used, anger management programs which focused on coping strategies and a range of cognitive behavioural therapy (CBT) and dialectical behavioural therapies (DBT).

People we spoke with told us they benefited from the treatments and stated they helped them improve in the development of psychological well-being.

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 is 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.

We also found where people had sensory needs relating to noise, wards were still in the process of upgrading their facilities to ensure these needs were met. This meant the service was not always meeting the expectations of NICE Guidelines CG142 Autism: recognition, referral, diagnosis and management of adults on the autism spectrum.

We saw evidence in case records that people did have access to doctors and other health staff when they required medical help. We saw in records of one person where they had inserted objects into themselves they had been referred to a specialist consultant to discuss the treatment required to have the inserted object removed.

We also saw in another person's records where they had a specific health condition they had been referred to another consultant to seek advice regarding the medication and treatment required to treat the person's health condition.

We looked at the records of five people where they had accessed health care services and spoke with some individuals. People who use the service told us "I can see the doctor when I need to, I have recently seen a doctor because I had cold."

We found the ward had a range of activities available to people throughout the day and weekend which included independent living skills, recreational meaningful activities and also educational skills by way of teaching.

People who used the service told us they enjoyed the activities available and did not get bored, however they expressed disappointment when activities were cancelled because staff were not always available.

We looked at how the service delivered "opportunity and goal planning" and found improvements could be made. For example where one person stated in their care plan

they were interested in becoming a mechanic there was no details in the person's support plan about how they would be supported to achieve this goal in terms of education and work experience.

We found the attitude of some staff dismissive. One member of staff told us "they are children, they change their minds regularly what they want to do when they get older and some of the goals are not realistic". People should be appropriately supported to achieve their aspirations. Failing to do so is detrimental to the long term well-being of young people with mental health conditions.

We spoke with staff and mangers on each of the wards about their understanding of children's rights and the UN Convention of Rights of the Child and also the Children's Act. We found the knowledge of most managers to be very limited. For example staff were unsure what we were referring too and how that impacted on the care young people received. Staff told us they had not received any specific training on either of these topics.

We saw examples of where training would have proved beneficial. For example where people had difficult relationships with their families a child's right to have a voice and be party to decisions was absent. Clinical and nursing staff had limited knowledge to ensure their rights were taken into account as in accordance with UN Convention and the associated articles contained within it.

The service had a safety risk management system and depending on what level a young person was judged at depended on the privileges they could have in terms of escorted supervised and unsupervised leave. We found that the same restriction levels were applied elsewhere in the hospital and that they were not child focused. For example each young person did not have their own individual plan with objectives on what they needed to achieve to enable them to have further leave privileges.

We spoke with ward mangers who acknowledged our concerns with the system and told us they would make improvements. One manager was able to show us in relation to one person where they had developed an individual plan because the person's cognitive abilities meant they were unable to understand the hospital safety levels and what was expected of them.

We found clinical audits were completed. Managers we spoke with told us about their responsibility to monitor activity engagement and where this fell short other professionals such as psychologists and occupational therapists were involved in improvements. We were told by ward managers that staff engaged people proactively in activities and that these were measured on a monthly basis regarding enjoyment and engagement of the task/activity provided.

Skilled staff to deliver care

Each ward we visited had its own input from a range of professionals such as pharmacists, occupational therapy, and psychology. It was evident that they played an active role in the wards as during our visit we observed them engaging people in activities such as football, and other sports as well as doing individual sessions with people around sexuality and sex.

We spoke with one psychiatrist who told us how engaged the pharmacy team were at St Andrew's. They were able to explain in detail how audits had identified issues in prescribing practices and this enabled improvements to be made immediately.

We spoke with a range of professionals including nursing and support staff who told us they received suitable training with the exception of specialised training in positive behaviour support and children's rights. Staff told us they were appraised on a yearly basis. We were unable to look at supervision records relating to topics discussed, because each member of staff kept their supervision records personally and these were not stored on the hospital system.

We spoke with staff about group supervision and reflective practice. They told us this was something they engaged in. One ward we visited told us reflective practice was led by the ward psychologist. It was evident looking at records held on the system that reflective practice took place. We saw a full group discussion had taken place for one person where the service struggled to engage with them due to the complex needs of the individual.

Multi-disciplinary and inter-agency team work

The service had developed relationships with community mental health teams care co-ordinators and local authority social services. This was generally done on initial admission to the service or when a person was discharged.

We were able to identify that when people were discharged the CAMHS service had engaged with external partners to support with a smooth transition between services. It was

evident in records this was very MDT lead. We were able to see how the service engaged individuals within that process by giving them an opportunity to visit future placements.

We did find however for one ward there had been a lack of discharge planning. For example it was a rehabilitation ward and only one person had a discharge plan in place. We spoke with the ward manager and asked what further arrangements were in place regarding other people on the ward and were told "we have only started to think about discharge plans." This had concerned us given that some people had been on the ward for years and this had not been a consideration.

Adherence to the MHA and MCA Code of Practice

The CQC Mental Health Act reviewer and inspectors looked at 12 care and treatment records, including seclusion records, across the wards. They found that the records were kept accurately and in line with the Mental Health Act code of practice.

When they checked the T2 and T3 medication records, they found that these were not always accurate. Some specified medication that the person was no longer taking, or did not always represent the dosage of medication the person was taking, and was over the BNF recommended limit.

Patients we spoke with were aware of their rights. Section 17 leave and access to visitors, was used in conjunction with the generic risk safety system. This was not in line with Mental Health Act code of practice, Chapter 19, which has clear guidance regarding restriction or exclusion of visitors.

Good Practice in applying the MCA

Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to manage risk. Some of the blanket restrictions relating to people having time off the ward and visitors were not in line with the principles of the Mental Capacity Act or Mental Health Act.

Our specialist advisor and inspectors spoke with a number of consultant psychiatrists, nursing staff and support staff , who demonstrated an understanding of the Mental Capacity Act. The ward social workers took a lead role in identifying when there may be indication to use deprivation of liberty safeguards..

Are child and adolescent mental health services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at the care records of 16 people across nine wards and found that's they were not personalised, holistic and recovery focused. Improvements were required.

The service used the support plans "my shared pathway" which is evidenced based practice and each person had a copy of the plan if they wished. People we spoke with told us they were aware of their plan and its contents but did not understand what it was for.

We found there was a range of professionals involved in people's care such as psychologists, occupational therapists, speech and language therapists, psychiatrists and also nursing and support staff that were responsible for the day to day delivery of care.

We identified that each professional would input their reports and recommendations onto each person's case notes but the detailed information provided was not always transferred in the care plans of individuals which meant that there was not always a unified approach to delivering care.

For example where people displayed behaviours such as inappropriate sexualised behaviour there was information in psychology reports which detailed strategies and interventions staff could use to manage people's behaviour. This information was not detailed in the daily care plans staff used to support people. We spoke with nursing staff and they were unable to explain the strategies and interventions identified in the psychology reports which meant they were not reflecting on this information whilst planning and delivering people's care.

We spoke with managers and support staff regarding our findings who acknowledged our concerns. The feedback we received was the system used for reporting and writing care plans is of a complex nature. Nursing staff told us it was often difficult to find the information but accepted daily care plans regarding strategies and interventions could be improved.

Requires improvement

Child and adolescent mental health services

We looked at how people's physical health care needs were managed and found although people had physical examinations when they were needed and were referred to a health professional when required, the service had not followed the Department of Health's Guidance on health action plans. None of the young people with autism or learning disability had a plan in place. A health action plan details the support required so people with learning disabilities and autism can lead healthy lives. It identifies potential health concerns and promotes a positive well-being for the person identifying the emotional and psychological needs of individuals. None of the people residing at St Andrew's benefited from this approach to maintain positive healthy lives despite some people on some wards having a learning disability and/or autism.

Best practice in treatment and care

We looked at the medication practices within the service and found clinicians working in the service had adopted the principles contained with Royal College of Psychiatrists (2007) Challenging Behavior: A unified approach. Clinical and service guidelines college report CR 144 because clear reasoning was detailed regarding the use of antipsychotic medication where people displayed aggressive, violent and disturbed behaviour.

It was also evident that people's medication was continually reviewed and where changes had occurred these had been done within the legal framework. However we did bring to the attention of clinicians one example of where appropriate legal steps had not always been followed in relation to prescribing medication under the Mental health Act 1983 documentation.

We spoke with psychologists working in the service and were told of a range of psychological therapies used to support people with their mental health conditions. For example treatments relating to sexualised behaviour were used, anger management programs which focused on coping strategies and a range of cognitive behavioural therapy (CBT) and dialectical behavioural therapies (DBT).

People we spoke with told us they benefited from the treatments and stated they helped them improve in the development of psychological well-being.

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 is 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.

We also found where people had sensory needs relating to noise, wards were still in the process of upgrading their facilities to ensure these needs were met. This meant the service was not always meeting the expectations of NICE Guidelines CG142 Autism: recognition, referral, diagnosis and management of adults on the autism spectrum.

We saw evidence in case records that people did have access to doctors and other health staff when they required medical help. We saw in records of one person where they had inserted objects into themselves they had been referred to a specialist consultant to discuss the treatment required to have the inserted object removed.

We also saw in another person's records where they had a specific health condition they had been referred to another consultant to seek advice regarding the medication and treatment required to treat the person's health condition.

We looked at the records of five people where they had accessed health care services and spoke with some individuals. People who use the service told us "I can see the doctor when I need to, I have recently seen a doctor because I had cold."

We found the ward had a range of activities available to people throughout the day and weekend which included independent living skills, recreational meaningful activities and also educational skills by way of teaching.

People who used the service told us they enjoyed the activities available and did not get bored, however they expressed disappointment when activities were cancelled because staff were not always available.

We looked at how the service delivered "opportunity and goal planning" and found improvements could be made. For example where one person stated in their care plan

they were interested in becoming a mechanic there was no details in the person's support plan about how they would be supported to achieve this goal in terms of education and work experience.

We found the attitude of some staff dismissive. One member of staff told us "they are children, they change their minds regularly what they want to do when they get older and some of the goals are not realistic". People should be appropriately supported to achieve their aspirations. Failing to do so is detrimental to the long term well-being of young people with mental health conditions.

We spoke with staff and mangers on each of the wards about their understanding of children's rights and the UN Convention of Rights of the Child and also the Children's Act. We found the knowledge of most managers to be very limited. For example staff were unsure what we were referring too and how that impacted on the care young people received. Staff told us they had not received any specific training on either of these topics.

We saw examples of where training would have proved beneficial. For example where people had difficult relationships with their families a child's right to have a voice and be party to decisions was absent. Clinical and nursing staff had limited knowledge to ensure their rights were taken into account as in accordance with UN Convention and the associated articles contained within it.

The service had a safety risk management system and depending on what level a young person was judged at depended on the privileges they could have in terms of escorted supervised and unsupervised leave. We found that the same restriction levels were applied elsewhere in the hospital and that they were not child focused. For example each young person did not have their own individual plan with objectives on what they needed to achieve to enable them to have further leave privileges.

We spoke with ward mangers who acknowledged our concerns with the system and told us they would make improvements. One manager was able to show us in relation to one person where they had developed an individual plan because the person's cognitive abilities meant they were unable to understand the hospital safety levels and what was expected of them.

We found clinical audits were completed. Managers we spoke with told us about their responsibility to monitor activity engagement and where this fell short other professionals such as psychologists and occupational therapists were involved in improvements. We were told by ward managers that staff engaged people proactively in activities and that these were measured on a monthly basis regarding enjoyment and engagement of the task/activity provided.

Skilled staff to deliver care

Each ward we visited had its own input from a range of professionals such as pharmacists, occupational therapy, and psychology. It was evident that they played an active role in the wards as during our visit we observed them engaging people in activities such as football, and other sports as well as doing individual sessions with people around sexuality and sex.

We spoke with one psychiatrist who told us how engaged the pharmacy team were at St Andrew's. They were able to explain in detail how audits had identified issues in prescribing practices and this enabled improvements to be made immediately.

We spoke with a range of professionals including nursing and support staff who told us they received suitable training with the exception of specialised training in positive behaviour support and children's rights. Staff told us they were appraised on a yearly basis. We were unable to look at supervision records relating to topics discussed, because each member of staff kept their supervision records personally and these were not stored on the hospital system.

We spoke with staff about group supervision and reflective practice. They told us this was something they engaged in. One ward we visited told us reflective practice was led by the ward psychologist. It was evident looking at records held on the system that reflective practice took place. We saw a full group discussion had taken place for one person where the service struggled to engage with them due to the complex needs of the individual.

Multi-disciplinary and inter-agency team work

The service had developed relationships with community mental health teams care co-ordinators and local authority social services. This was generally done on initial admission to the service or when a person was discharged.

We were able to identify that when people were discharged the CAMHS service had engaged with external partners to support with a smooth transition between services. It was

evident in records this was very MDT lead. We were able to see how the service engaged individuals within that process by giving them an opportunity to visit future placements.

We did find however for one ward there had been a lack of discharge planning. For example it was a rehabilitation ward and only one person had a discharge plan in place. We spoke with the ward manager and asked what further arrangements were in place regarding other people on the ward and were told "we have only started to think about discharge plans." This had concerned us given that some people had been on the ward for years and this had not been a consideration.

Adherence to the MHA and MCA Code of Practice

The CQC Mental Health Act reviewer and inspectors looked at 12 care and treatment records, including seclusion records, across the wards. They found that the records were kept accurately and in line with the Mental Health Act code of practice.

When they checked the T2 and T3 medication records, they found that these were not always accurate. Some specified medication that the person was no longer taking, or did not always represent the dosage of medication the person was taking, and was over the BNF recommended limit.

Patients we spoke with were aware of their rights. Section 17 leave and access to visitors, was used in conjunction with the generic risk safety system. This was not in line with Mental Health Act code of practice, Chapter 19, which has clear guidance regarding restriction or exclusion of visitors.

Good Practice in applying the MCA

Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to manage risk. Some of the blanket restrictions relating to people having time off the ward and visitors were not in line with the principles of the Mental Capacity Act or Mental Health Act.

Our specialist advisor and inspectors spoke with a number of consultant psychiatrists, nursing staff and support staff , who demonstrated an understanding of the Mental Capacity Act. The ward social workers took a lead role in identifying when there may be indication to use deprivation of liberty safeguards..

Are child and adolescent mental health services caring?

Kindness, dignity, respect and support

We observed how people were cared for on each of the wards we visited and found people were treated with dignity and respect.

Nursing and supporting staff showed interest in the young people they cared for and a willingness to ensure that each person was able to have a meaningful and fulfilling life.

One nurse commented "many people come from difficult situations and as well as being a nurse we have to parent some of the young people because they are so young."

We saw staff engaging people in age appropriate activities such as table tennis and games. All of the wards we visited had calm and relaxed atmosphere where it appeared both staff and patients had a mutual respect for each other.

Young people we spoke with talked positively about the staff who cared for them. One person told us "they really help me, I wouldn't be as well now if it wasn't for them".

Another person told us "you get on with some better than others but they are all good, nobody treats us bad".

We looked at how the wards met the equality and diversity needs of people and found people were supported. For example we saw in some people's records where they struggled to understand their sexual identity that the organisation had made links with external charities and network groups to come to the hospital and talk to people on an individual basis.

We asked the ward managers if there were any patient LGBT network groups they could join as well as any other groups and were told these were all accessed externally. This meant that people did not always have the opportunity to participate in group equality and diversity networks. This is an area the provider could improve.

The involvement of people in the care they receive

We asked patients about the admission process and how they were oriented to the ward. We found on one ward patients had been involved in developing a booklet for all

other patients who came to the hospital. The booklet contained information about the facilities available at the hospital, how people could complain and also information regarding advocacy.

Patients we spoke with told us they were able to access advocacy services when they wanted. We were told by ward managers that representatives from the service came to patient meetings and helped people make complaints if they needed to and support them in any other areas they raised issues about.

People had a care programme approach (CPA) meetings. We spoke with each of the ward managers who told us many patients because of their age and understanding tend not to lead their CPA. All ward managers we spoke with told us they want people to lead their CPAs and understand the importance of doing so.

We spoke with young people about their involvement in care planning and most of the comments we received were "I know I have a care plan but I'm not sure what it is for."

We looked at how people's family and carers were involved in care plans and found for many that there was no involvement. We spoke with nursing staff on the wards and they explained that due to many family dynamics it was difficult to engage relatives and family friends. Staff told us they did the best they could.

We looked at visitor records to the wards and did find there was an absence of family visits but young people we spoke with told us they were able to use skype and other electronic ways of staying in touch with their family and friends.

One ward manager told us about one person who had friends that came to visit one young person on planned visits and they were able to show us documentary evidence this had occurred. The manager was able to show us they had arranged the visit and worked with other external health professionals to enable the visit to proceed.

Are child and adolescent mental health services responsive to people's needs? (for example, to feedback?)

Requires improvement

Access, discharge and bed management

On most wards we visited discharge was a key principle and was planned at the point of admission. However one ward we visited we found there was an absence of discharge planning. We spoke with the registered manager who acknowledged our concerns and told us this had been highlighted as an area of improvement. They explained to us that CAMHS does not have an overall clinical lead unlike other parts of the hospital and this can often mean that wards prioritise their work in different ways.

We asked what arrangements were in place when people were on agreed leave or were going through a transition period to new placements. We were told people's beds were fully available until they were discharged which meant the service did not fill unoccupied beds until the person was fully transferred.

We looked at how people were moved around the hospital and found it was dependant on their progress. People would be moved from admission wards to other longer stay wards once their course of treatment had been identified. Ward managers told us people would not move people for any other reason unless there were any safeguarding issues which meant people did require to be moved. We saw in the records of one person on one ward were they had been moved to another ward because they were bullied by other people on the ward and the situation was becoming untenable for the person.

The service had a number of what they referred to as "extra care" beds. These were generally segregated from the main parts of the ward and people were cared for in isolation. We spoke with the staff and ward managers regarding the provision of this service and were told the hospital policy on the use of "extra care" beds was ambiguous and didn't really define what was meant.

The ward environment optimises recovery, comfort and dignity

Child and adolescent mental health services

Each ward we looked at had a range of facilities which included a treatment room and activity rooms so people could have their clinical care needs met and also a place to enjoy recreational activities.

Some wards we went to had designated spaces for people to meet with relative and friends. Where some wards did not provide these facilities there were spaces within the hospital facility where people could meet with their family and friends.

We saw on each of the wards there were telephone facilities so people could contact their friends and relatives in a private place to ensure privacy.

Some of the wards we went to had an outside space where people could play all weather sports such as football, netball and basketball, as well as enjoy the freedom of being outside in a safe environment.

Although some other wards did not have all of the facilities as detailed above, they did have space where people could enjoy fresh air.

We looked at what accessible information was provided to patients and found care plans (my shared pathway) were written in an easy read format. The service had a complaints policy which was also available in an easy read format and was displayed on most wards we visited. We also found that there was a patients' rights handbook which had been completed in an easy read format. Patients we spoke with told us they were happy with the way that information was provided. One person told us "I understand most of the information and if I don't the staff help me". We did find that some of the information was still targeted mainly for adults and therefore the service could improve by designing accessible information for children.

Young people we spoke with were happy with the food, but did state that portions sometimes were too small. They told us they were encouraged to eat healthy and they were allowed two snacks per week. This was confirmed when we spoke with staff. Young people told us that food was often a discussion on the patient ward community meetings where they are given opportunity to discuss the types of food they would like. The service had recently appointed a new cook and patients told us food quality was much better than it had been previously. One person told us "the chef came to our community meeting and asked us what types of food we wanted". This demonstrated patient views were seen as important when preparing menu choices.

Ward policies and procedures minimise restrictions

There were some blanket restrictions in place such as young people were prevented from having sugar due to the healthy eating initiative that the hospital had developed.

We were told this was patient lead by senior managers but the wards we visited told us it was hospital driven. Whilst CQC agrees that hospitals should promote healthy eating it is equally important that detained patients should enjoy equal rights as others about choosing a diet they want and supported to make healthy choices to improve health and well-being as opposed to have ideals put upon them.

We also found there were restriction regarding the use of phone calls such as people were only allowed 20 minute calls on an evening. Whilst therapy is important it has to be appreciated that a 20 minute phone call on an evening when many young people do not have the opportunity to see their relatives for weeks is restrictive. The hospital needs to consider the needs of children and the importance of young people to develop and maintain their relationships with their family and friends.

We looked at the bedrooms of some patients with their permission and found that they had been personalised in the way in which they chose. Patients told us that staff were generally relaxed about what they put on the walls "as long as it wasn't pornography".

Listening to and learning from concerns and complaints

People we spoke with told us they knew how to complain but often felt they were not listened to. People told us they had made complaints about bullying on the wards by their peers but this often was ignored by staff and although the paperwork was completed they did not get any response from the senior teams.

We spoke with staff regarding some of the comments we had received and they told us that once the matter had been investigated they were usually asked to discuss the feedback with patients.

Requires improvement

Child and adolescent mental health services

Are child and adolescent mental health services well-led?

Requires improvement

Vision and values

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

Good governance

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

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

Leadership, morale and staff engagement

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

Commitment to quality improvement and innovation

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

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

Good

Services for older people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

O'Connell Ward

O'Connell is a 22-bed locked ward specialising in providing specialist services for older men aged over 55 with acquired, static or progressive neurological conditions or enduring mental health needs.

Compton Ward

Compton is a 19-bed locked ward specialising in services for older men and women aged over 55 with acquired, static or progressive neurological conditions who may have enduring mental health needs.

Daniel Rambaut Ward

Daniel Rambaut is a 13-bedded locked service for men aged over 40 with acquired, static or progressive neurological conditions resulting in additional mental health needs

Summary of findings

The service appeared to have an open culture focused toward providing the highest possible quality of care, individualised to each patient's needs. Care was reviewed by the clinical team on a weekly basis and changes communicated to staff through meetings, handovers and specific communication books.

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 on Compton ward

All regular staff were up to date with training and it was clear the learning was being used in everyday practice. Staff appeared passionate about care and were respectful and caring in their approach to patients. We noted the manner in which they addressed patients' distress was focused on maintaining the person's dignity.

The large wards were being used innovatively to create areas of interest for patients and these were utilised to assist in care. For example, a male lounge had been transformed into a pub with displays and it was noted that one patient ate better in this environment so it became part of his care to "go to the pub" for lunch. We saw his nutritional intake had improved since this began.

The service had a project for addressing the latest published guidance and research relating to their work. This was to investigate how it could be incorporated into the care provided to patients.

Good

Services for older people

The service used a programme called dementia care mapping (DCM). This was an observational tool used in care settings to look at quality of life from the viewpoint of the patient. The service was working with the University of Bradford dementia group who were in the process of developing a similar project.

Are services for older people safe?

Requires improvement

Safe and Clean Ward Environment

The wards were large and housed in the main grade 1 listed building. This meant there was the possibility that patients could be unobserved. However staff were allocated to the main areas to ensure patients were observed and there was a regular check of patient's location was undertaken.

We saw ligature risk and environment audits were undertaken every six months. The clinic room was fully equipped and resuscitation equipment was checked regularly.

On the tour of the wards, we noted the ward and bedroom areas were clean and tidy. However, on arrival on two wards, we were not asked to use the disinfectant hand gel or it was not available. We highlighted this to the manager who addressed our concern immediately.

Safe Staffing

A staffing tool was used to calculate the correct staffing ratios and during our inspection, we saw the numbers had been maintained including at least one qualified and experience nurse at all times. The managers told us they do use the staff bureau on occasions but attempt to use staff that are familiar to the ward and patients to ensure continuity of care. Patients told us they felt safe and cared for. The relative we spoke with praised the dedication, knowledge and professionalism of the staff.

Assessing and managing risk to patients and staff

Every person had a comprehensive risk assessment prior to admission and we saw these were discussed along with the care plans each week at review and formally updated on a monthly basis. The wards used a risk matrix detailing the levels of risk and actions to take should they need to increase staffing input for a patient to ensure their safety. Staff were familiar with this system and were able to explain how it worked and was reviewed.

Staff were up to date with training in safeguarding and demonstrated the ability to apply this to the patients. The

staff were able to describe their actions if they had concerns and knowledge of external agencies that they could approach. There was good medicines management practice on these wards.

Reporting incidents and learning from when things go wrong

Staff were able to tell us the reporting procedure for incidents. There were shift handovers which included level of risk and priorities for individual patient care. Staff had a clear understanding of what should be reported and to whom. They received feedback and learning points from incidents through staff team meetings, shift handovers and a specific communication book for incident outcomes and lessons. We saw several examples in care records of practice being altered as a result of incidents and this being reviewed over time.

Are services for older people effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care

Every patient had a full assessment of their needs. We found 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.

Best Practice in treatment and care

The medication records demonstrated adherence to professional guidance and we noted referrals had been made to specialist services where required. The wards had an activity programme which was supplemented with individual activities for those unable to participate in groups. Staff used a nationally recognised rating scale to measure patient's recovery.

During our inspection, we witnessed audits being undertaken including infection control, medication records and clinic room equipment.

Skilled staff to deliver care

In addition to the nursing staff, the wards received input from psychologists, consultant psychiatrists, occupational therapists, physiotherapists, speech and language therapist, social workers, pharmacist and a dietician.

Staff received supervision on a monthly basis in addition to a weekly reflective practice session facilitated by the psychologist. We saw the training record which confirmed staff were up to date with training including all mandatory topics. Appraisal of performance was undertaken annually.

Multi-disciplinary and inter-agency working

Handovers detailed with care required for each patient and their current condition. Information was brief but extra details given where the patient's condition required it. The wards had a multi-disciplinary meeting every week for in depth discussion about care which involved the patient and relative (where possible). Staff told us there was a communication book which they always read on arrival to the ward as it contained important information about the patient's care and the ward environment.

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.

Adherence to MHA and the MHA Code of Practice

We looked at the Mental Health Act paperwork for patients and found it to be accurate and complete in all sections. This meant that patients were not illegally detained or treated. All consent to treatment paperwork was present and correct.

Good Practice in applying the MCA

Staff were trained in the Mental Capacity Act and the Deprivation of Liberties Safeguards (DoLS). All staff we spoke with were able to tell us in detail how this related to the patients. In reviewing the care records, we found detailed capacity assessments relating to different aspects of the patients life and care provision. These were reviewed at the weekly team meetings.

Most patients were detained under the Mental health Act. However the other patients were subject to a DoLS order. The proper process had been followed and paperwork was completed accurately with review dates set as required.

Good

Services for older people

Are services for older people caring?

Good

Kindness, dignity, respect and support

We observed little activity or interaction between staff and patients on the wards we visited. The exceptions where with the exception of Bradlaugh ward, where a healthy living fayre was taking place, and Harlestone, where patients were involved in OT activities.

Patients gave a varied view of how they were treated. Some patients told us that they were well cared for and they had no concerns about the staff. Some patients felt angry and frustrated by how they were treated, stating that staff did not listen to them and that they did not like how staff spoke to them. Some staff told us that they were concerned that the restrictive routines in place affected how they were able to care for people individually. For example, the emphasis to meet the 25 hour activity target took priority over what the individual might want to do.

The involvement of people in the care they receive

Patients were encouraged to attend their care management meetings. We saw that some patients were supported to complete a form to take in with them, or give to the MDT if they did not wish to attend. In the CPA meeting we observed, it did not appear that people were listening to the patient. We observed that sometimes clinicians used language that the person could not understand.

There was little evidence that patients or their carers were actively involved in writing or reviewing their care plans. Most patients we spoke with did not have a copy of their care plan and could not identify goals. Some patients were aware that they could request a copy. On Bradlaugh Ward the patients had copies of their care plans in their rooms but not in a format that they could understand. For example, one person had a written care plan but they were not literate. Hawkins ward staff advised us that people didn`t have copies in order to protect their personal information. None of the patients we spoke with had drawn up, or had a copy of, a health action plan.

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. We saw a report from Voiceability for July 2014, which showed that patients were contacting them regularly.

Each ward had weekly community meetings, with patients and staff. We saw meeting minutes from these. There were some support and engagement projects with the patients on the wards, from the patient experience team. We spoke with patient representatives, they told us that they felt listened to in meetings they attended.

Are services for older people responsive to people's needs?

(for example, to feedback?)

Good

Access, discharge and bed management

The wards accepted patients from across the country providing a specialist service which may not have been available in their home area. We saw discharge planning began soon after admission and a strong connection was maintained with the patient's professional team in their home area.

The ward environment optimises recovery, comfort and dignity

The wards were large and provided ample space for patients to exercise and be able to find a quiet area and for privacy during visits. The ward managers told us the space was a challenge to make feel homely and we saw they had utilised the ends of corridors to create small areas of interest such as a reading area and TV corner in addition to the lounges and activity rooms.

O'Connell ward was on the first floor with no outside space. We did however see patients being taken out into the grounds during our visit and the manager told us they were waiting for final approval to create a roof terrace garden.

Section 16.9 of the Mental Health Act code of practice speaks about gender separation. Prior to our inspection, an issue on Compton Ward had been highlighted to us. We investigated this in depth during our visit and found robust

assessments had been undertaken around the decision to place this patient in that particular area. The hospital directors and ward management team reviewed the situation during our visit and the issue was resolved.

Other prior concerns related to male patients walking through the female ward areas to access the garden and patients having to access the baths in the opposite gender area. Due to the ward layout, this was not possible to resolve. The ward management showed us how they manage this in a way to preserve patients' dignity. There was no shower facility on the ward however we heard about the plans being formulated to install a wet room.

All 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.

Ward policies and procedures minimise restrictions

We found no blanket restrictions on the ward. All care was personalised and any restrictions for individuals were risk assessed, documented and reviewed regularly.

All patients were subject to the Mental Health Act or a Deprivation of Liberties restriction. However we noted signs informing us that any informal patients were able to leave the ward when they wished.

Patient's bedrooms had been personalised with their own furniture, belongings and photographs.

Meeting the needs of all people who use the service

The information boards displayed details of how to access information in a variety of languages including how to access a sign language interpreter. Information was also available in an "easy read" format with pictures to assist understanding.

We noted there were patients from different religious beliefs and a dietary care plan in respect of these requirements. We also noted in personal care records respect for cultural preferences for the gender of staff providing care.

Listening to and learning from concerns and complaints

Patients we spoke with told us they spoke to the staff if they were unhappy about anything. Staff were aware of the capacity issues many patients had and were able to tell us how they would help a patient to make a complaint. This included they would know through body language and other non-verbal communication when a patient was unhappy. All staff highlighted their action of involving advocates for people if required.

Each ward had a book dedicated to learning from incidents and complaints generated across the hospital site. This ensured learning not just from their own ward but from other services. We saw action plans arising from complaints and the resultant changes on the wards.

Are services for older people well-led?

Good

Vision and Values

The ward staff showed an awareness of the wider organisation's values however this was poor in comparison with the staff awareness and passion at a service level. The older adult service management team were motivated toward providing the best practice and high quality care which clearly filtered through to their staff at every level of seniority.

We were told that staff would probably recognise the new chief executive but would be less likely to be able to describe his role or any of the other members of the organisation's senior directors.

Good Governance

The ward managers told us they felt supported in their roles and had excellent support from the directors of the service. There appeared to be a robust monitoring system used within the service, data from which was fed into the organisation's audit / quality department. We found that there appeared to be a disconnect between the service auditing and the organisation's department. We were told by the management that action plans were generated by the organisation's department which were returned to the wards for completion. However, staff told us that on occasions these actions had been completed before the official plans had returned to the ward. Although showing efficiency of the service, it could mean that actions may be missed and the organisation department's data and records not accurate.

Good

Services for older people

There were systems in place to ensure learning from incidents and complaints from across the wider organisation as well as in the service itself.

Leadership, morale and staff engagement

The senior management across the service demonstrated a strong sense of leadership which staff told us they appreciated. Sickness and absence rates were low in comparison with the rest of the organisation and staff told us they felt able to raise any concerns without the fear of reprisal. Staff told us they felt listened to and their views were respected. We found that staff teams appeared to have a good level of morale despite the challenging nature of their work. Staff clearly told us they felt part of the team.

Staff did express a concern about the recent changes in management and said they hoped that the managers now would remain in post as they felt this had affected staff morale in the recent past. We were assured by the senior management that they had gone through a period of change and, with the new managers now in post, no further changes in management were planned for the foreseeable future.

Commitment to quality improvement and innovation

We saw the service had an audit calendar to ensure care was being monitored effectively. The ward was participating in a number of projects designed to improve patient experiences and quality of care. For example, the daisy group which examined published guidance from the National Institute for Health and Care Excellence and other leading bodies.

We saw the use of displays to transform rooms into different scenes providing areas of interest and variety in the environment. For example, a male lounge was transformed into a pub scene which was reminiscent for patients and an activity room transformed into a dance hall. These displays were transportable and usable in each of the wards.

The service used a programme called dementia care mapping (DCM). This was an observational tool used in care settings to look at quality of life from the viewpoint of the patient. The service was working with the University of Bradford dementia group who were in the process of developing a similar project.

Requires improvement

Services for people with learning disabilities or autism

Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Information about the service

St Andrew's offers medium and low secure specialist services for adults with mild/borderline learning disabilities and challenging behaviour, including individuals who may also have a mental health problem and offending history. They also have care pathways and wards specifically for adults diagnosed with autistic spectrum disorder (ASD).

The services are located at Northampton. We visited the 5 male wards located in Northampton, accepting admissions for men aged 18 to 60 years, who meet their criteria.

- Hawkins Ward is a 15 bedded medium secure service for men with learning disability, and forensic and challenging behaviour.
- Mackaness Ward is a 15 bedded medium secure service for men with a diagnosis of autistic spectrum disorder, who may also have associated mental health needs, challenging or offending behaviour.
- Harlestone Ward is a 20 bedded low secure service for men with a diagnosis of autistic spectrum disorder, who may also have associated mental health needs, challenging or offending behaviour.
- Ferguson Ward is a 16 bedded low secure unit for men with learning disability, and forensic and challenging behaviour.
- Bradlaugh Ward is a 12 bedded locked rehabilitation ward for men with learning disability, and forensic and challenging behaviour.

Summary of findings

- We found that there were not always enough members of staff to care for people safely. Some staff and patients told us that they did not always feel safe on the wards.
- There were safeguarding processes in place on all wards. However some staff we spoke with could not clearly explain what a safeguarding concern was or when it would need to be escalated to external agencies.
- There were not clear systems to ensure that agency and bank staff were aware of safeguarding protection plans on the wards that they were working on.
- We were concerned that there appeared to be routine restrictive practices in place to assess and manage risk, irrespective of individual needs and risks.
- Information about the complaints process was not clearly displayed on the wards in formats people could understand.
- We found that patients told us that they did not feel that their complaints were always listened to or acted on. Patients told us that they did not get always feedback from their complaints.
- Independent investigations were undertaken if complaints were `upheld`. However, most complaints were recorded as `not upheld`, if they had been resolved at a local level. This could mean that potential themes on the wards were not investigated appropriately.

Requires improvement

Services for people with learning disabilities or autism

- We were concerned that the CQC have not been sent 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.
- Seclusion facilities were being routinely used for de-escalation and time out and not recorded as seclusion.
- Patient care and risk was not assessed, planned and managed 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.
- 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.
- 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

Are services for people with learning disabilities or autism safe?

Requires improvement

Safe and clean ward environment

Harlestone, Hawkins and Mackaness wards were newer facilities. Bradlaugh and Ferguson were in older parts of the hospital. Potential ligature points were managed as part of individual and unit risk assessments. Regular ligature audits were undertaken by the central audit team and were completed 6 monthly. We saw audits had been undertaken on all wards in July 2014. There were areas with clear lines of sight which enabled staff to monitor patients who needed closer observation. Staff were allocated to work in areas of the ward where line of sight may be restricted.

We observed that the wards were clean and free of odours. Regular room audits were undertaken by the wards. The décor was quite bare and neglected, particularly on the older wards, although Harlestone and Bradlaugh wards had some artwork on the walls. We observed that all of the wards had a suitable clinic room. However, not all wards had resuscitation equipment; these were located on nearby wards. There was an established emergency protocol in place, which staff explained clearly to us. However, we were concerned that in the event of an emergency, 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.

The seclusion facilities did not meet with the Mental Health Act code of practice minimum standards. The line of sight in the en-suite bathroom area of seclusion on Mackaness was poor, which meant patients were required to urinate in a bottle if staff felt it was not `safe enough` to enter the en-suite. Bradlaugh ward did not have seclusion facilities. Bradlaugh ward used the seclusion room on Ferguson Ward, which was downstairs from them. We were told when seclusion facilities on Ferguson Ward were in use, the wards accessed Sherwood Ward seclusion facilities. We were concerned about the safety of moving people in a restraint situation, either downstairs or using a lift, which we were told was unreliable and had broken down several

times. We were concerned about patients being moved to the seclusion room on Ferguson ward also, as access to it included some steps and going through a narrowing corridor.

The wards had limited facilities for patients to raise an alarm, for example, nurse call bells in bedrooms. However, the ward staff undertook minimum hourly observations and regular safety nurse checks, an alarm could therefore be raised with a member of staff.

Safe Staffing

We found that there were not always enough members of staff to care for people safely. Some staff and patients told us that they did not always feel safe on the wards. We saw meeting minutes which showed there had been an increase in assaults on staff and patients on the men`s learning disability wards, in the last quarter, from April 2014 to August 2014. Hawkins Ward had the highest number of recorded incidents. Staff and patients told us that incidents of aggression sometimes happened because people were frustrated. We saw minutes from the men`s service patient safety meeting which acknowledged incident reports highlighting staffing as contributory factors in some incidents. We saw an action plan which showed that the senior management team were aware of this concern and there was a workforce plan in place.

Staffing levels were adapted when changes in people`s needs were identified. Where an increased staffing requirement was identified, for example if a person required 1:1 or 2:1 support, additional staff would be employed on the wards. We saw rotas which showed the wards were regularly using bank or agency staff. We observed agency and bank staff on the wards we visited. For example, Mackaness had 3 members of regular staff to 6 bank or agency staff members on the day we visited. We observed that agency staff were shown round the ward and given a brief overview of the patients by the safety nurse, but limited details about specific care needs. When we spoke with agency staff, they were not able to tell us about specific patient care needs, stating they would ask a member of staff. Agency staff and some bank staff were not able to access the electronic notes system despite reassurance from the charity that bank staff could.

Most staff told us that there had been regular occasions when there had not been enough staff to facilitate an activity session or to escort a patient outside. We also saw this reflected in a document which showed all the ward activities which had been cancelled due to inadequate staffing levels to supervise patients. We saw notes in some patients care records; leave or activities had been cancelled due to staffing, including home visits. Patients told us that they were upset and frustrated that they could not always attend activities or leave the wards as planned. Eleven patients on Harlestone Ward gave us a letter which outlined the impact of this issue.

Staff told us that they were able to contact a manager or doctor outside of working hours. Staff explained the process for doing this and we saw on-call rotas. Medical staff confirmed that they were part of this process.

Assessing and managing risk to patients and staff

Due to the complex needs of the people who use the service, some elements of choice and care were legally restricted, as some were detained under the Mental Health Act. Some areas of practice were in line with minimum safety standards of low and medium secure settings. However, we were concerned that there appeared to be routine restrictive practices in place to manage risk. The risk safety system provided an overall framework for the assessment and management of behaviour and risk across St Andrew's, Behaviours related to daily care and treatment were measured using generic levels, with little reference to individual risk assessments or care plans. Patients were allocated a level 1 – 5/6, depending on behaviour and risks. Level 1 was the most restricted; For example, all new patients admitted to the wards were placed on Level 1 or 2 (which restricted leave, visitors, and contents in bedrooms). Patients could move up or down the levels depending on their behaviour, determined by the nurse in charge or the MDT, in line with the system. For example, a minimum of 72 hours `settled behaviour` was required before moving from level 1 to 2. There did not appear to be an opportunity for patients to appeal against decisions made about levels allocated to them or clear, individual behaviour markers and goals, for change in levels. This system was not in line with Department of Health Positive and Proactive Care: Reducing the Need for Restrictive Practice guidance (April 2014) or the Mental Health Act code of practice.

The service had a number of policies in place, addressing a range of appropriate areas to manage risk. For example, policies addressing: searching, management of violence and aggression, observation, escort procedures. Most regular staff could explain how their ward used the

observation policy and how observations could be increased or removed. Some staff were concerned that they were on 1:1 observations with people for prolonged periods of time, without a break or change in staff. We saw an example of how observation paperwork was completed. We noted that patients were routinely searched and checked for contraband items when returning to Bradlaugh ward, a locked rehabilitation ward, irrespective of their individual risks.

The CQC Mental Health Act reviewer looked at eleven records across the 5 wards, including seclusion records on each ward. They found that the records were kept accurately and in line with the Mental Health Act code of practice. However, we were concerned a medic did not review a patient who harmed themselves by head banging whilst in seclusion on Hawkins Ward. The progress notes indicated that following the incident, the person was observed through the door to be asleep. They were not seen by a doctor until twelve hours after the incident.

We were concerned that seclusion facilities were sometimes used for `time out`. Patients would `voluntarily` go into seclusion with a staff member for `time out`. Staff on Ferguson ward told us this was due to the low stimulus room being out of action. Staff on Hawkins told us that this was a part of some patients' care plans. We saw one example in an individual`s care plan. The plan stated that the person would use their "bedroom or a quiet room" for time out, it did not state the seclusion room. Staff we spoke with did not view this action as seclusion and it was not recorded in the seclusion records. National Institute for Health and Care Excellence (NICE) CG25 guidance and the St Andrew's service seclusion policy clearly states that seclusion facilities should not be used for the purpose of de-escalation or time out.

There was a process to report safeguarding concerns to the nurse in charge, who would inform the ward social worker. The social worker reviewed these concerns and made external referrals where they deemed it necessary. External referrals were made in line with the St Andrew's policy. A regular discussion was held with the local authority regarding all other safeguarding issues, to monitor that referrals were made appropriately. We observed that safeguarding was discussed in MDT ward rounds and that there were individual protection plans agreed from these discussions. We saw from meeting minutes that safeguarding reporting was monitored and discussed in patient safety meetings.

The agency staff we spoke with did not know where to find out about current safeguarding issues on the ward. We were concerned that bank and agency staff would not be aware of relevant protection plans. For example, when one patient had been bullying another patient. Some staff we spoke with could not clearly explain what a safeguarding concern was or when it would need to be escalated to external agencies. One staff member told us that they would not pass everything patients told them on to the ward social worker, or "everything would be called safeguarding". We were concerned that some staff may not listen to concerns raised by patients or be aware of the need to take action if they observed something that was contrary to their protection plan. The July 2014 training report that 31% of staff in the men`s service had completed their Safeguarding Level 3 training.

Reporting incidents and learning from when things go wrong

Staff were aware of the incident reporting process. We saw that incident reports were dealt with in line with the St Andrew's policy and recorded on an electronic reporting system. The examples we saw showed that the information recorded in incident reports was clear and comprehensive. We were informed learning from incidents was published in bulletins on the intranet and we saw folders on each ward which contained these. We noted that few staff had signed to say that they had read the contents of these folders. Most staff could not give an example of an incident and shared learning from it. The ward staff meeting minutes we were given did not reflect that information about incidents was shared within this forum.

We were concerned that the CQC have not been sent 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. For example, we requested data around the numbers of assaults on the wards. The number of incidents reported did not correlate with the number of notifications sent to the CQC

Requires improvement

Services for people with learning disabilities or autism

Are services for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at ten electronic patient care records. We saw that these contained care plans for a range of physical, psychological and social issues and a risk assessment. Some of the care plans were generic and they were not always person centred and did not incorporate clear goals agreed with the person to work towards; particularly in relation to the risk safety system. We saw that comprehensive prevention, management of violence and aggression (PMVA) care plans were in place. However the care plans had not always been updated, or did not contain full information. For example, we noted a PMVA care plan on Hawkins ward contained a `?` as an agreed time period for an individual to "show settled behaviour" in order for seclusion to be ended. The `?` had remained in place despite the care plan having been updated.

We saw that notes 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. For example, we saw a care plan outlining how to manage a person`s diabetes. Progress notes were completed each shift, although some bank and agency staff were not able to use the electronic notes system.

Best practice in treatment and care

The risk safety system applied to most people on the wards, although we were told of a few individuals for whom this had not been put in place. We concluded that it was a restrictive, blanket approach, not individualised to take into account understanding the individual or function of a person`s behaviour. Staff from all disciplines told us that they were concerned that the patients did not always understand the levels in the risk safety system. Some staff told us that they felt it was restrictive and did not motivate or support patients to understand their behaviour or make changes. Staff told us that the risk safety system was sometimes used inconsistently, particularly between shifts. This caused problems if patients felt staff treated people differently. Some patients told us that they had experienced this. We saw meeting minutes which showed that this issue had been raised.

Most patients we asked could not clearly explain to us what the risk safety system was, although most knew which level they were on. Patients told us that the restrictions from the levels made them angry. We saw three recorded complaints made by patients about the system. We saw that Section 17 leave and visits from family could be affected by what level people were on. Relatives told us that they felt that the system was restrictive. One carer told us that they had been told not to visit due to a change in levels. We saw an Improving Lives document which reflected that the Improving Lives team, commissioners and family members felt this system was punitive. The current implementation of this system was not in line with Department of Health Positive and Proactive Care: Reducing the Need for Restrictive Practice guidance (April 2014) or the Mental Health Act code of practice.

A behaviour management system reinforce appropriate implode disruptive (RAID) was also used for some patients on Hawkins and Mackaness wards. From discussion with the staff and available information, we concluded that as this system was currently implemented, it was not in line with a positive behaviour support (PBS) approach. PBS requires individually tailored programmes, an understanding of the function of behaviours and the ability to support patients to engage with activities and focus on enhancing quality of life. We were concerned that the RAID system, as well as the risk safety system, as it was currently being implemented, may not be understood by patients with a learning disability.

The Commissioners of the service specified that patients should have a minimum of 25 hours per week of structured activity. The programme of treatment included occupational therapy and individual psychology sessions. We saw copies of ward and individual activity plans. There was a monitoring system in place to check if people are getting activities as planned. We saw that when activities were cancelled or people were unable to attend, this was recorded. We saw a provider paper from 2013, which stated that the risk safety system should not be used to manage non-risk behaviours, such as non-engagement. However, we saw that the system was being used in this way. Patient access to occupational work pathways were also restricted

depending on which level people were on. Some patients told us they felt angry that the levels and activities were linked. For example, one individual told us that if they did not attend, their level changes and they cannot go out. We also saw community meeting minutes from June 2014, which reflected that this was the blanket agreement for all the patients; that their levels would be `frozen` "unless they got up at appropriate times".

There were some activities available on the wards; for example, board games and pool. However, with the exception of Harlestone Ward, where we observed patients engaged with occupational therapy (OT) activities, we observed little ward activity or interaction between staff and patients. We were told that patients could only access the sensory room and ward kitchen with an occupational therapist, dependent on their risk safety system level. We observed patients were sat around or walking about the communal areas, throughout the inspection visits. Some patients told us that they were bored. Some patients told us that they felt angry and frustrated by this.

All patients had access to a primary healthcare service. There was a GP service and dentist on site, which was available to all patients if required. A physical healthcare nursing team also visited wards when required. We observed a physical healthcare nurse on Ferguson ward with a patient. Patients who required the services of a G.P, podiatrist, optician, dentist or physiotherapist were referred on a needs basis in order to access these services. Staff confirmed there was generally a timely response to referral

Most staff were not engaged with clinical audit of their wards. Most of the audits were undertaken by a central audit team. We saw some examples of these audits, such as health records review and an audit of the, prescribing of high doses of anti-psychotic medication. Staff we spoke with were not aware of which audits were undertaken or able to give an example of outcomes which affected their ward areas. The ward managers we spoke with were aware of action plans which were generated for their specific ward areas. We saw an example of an action plan for Bradlaugh ward and how this was discussed in their ward meetings. Some medical staff could not identify how actions from pharmacy audits, related to prescribing, were communicated to them.

Skilled staff to deliver care

There were multi-disciplinary teams (MDT) identified as part of the staffing establishment. Each team included psychiatrists, nurses, pharmacists, psychologists, occupational therapists, and social workers. Other allied professionals such as dieticians, teachers and speech and language therapists worked within the service and responded in good time to referrals. There had been a number of locum doctors in post.

Most staff told us that the training offered by St Andrew's was excellent. We saw a comprehensive training schedule. There were monitoring systems in place to record when staff attended required training. The July 2014 training report that 31% of staff in the men`s service had completed their Safeguarding Level 3 training. Staff told us that they were not always able to be released from their wards to attend, due to staffing levels. The training report published in July 2014 reflected that there had been 29 non-attendances recorded due to staff not being released from the wards.

Staff we spoke with confirmed that they had regular supervision. We saw forms which had been signed to indicate supervision had taken place. Reflective practice and ward meetings were not always held. This depended on other members of the MDT providing support on the ward to release the staff.

Multi-disciplinary and inter-agency team work

There was not a clear and effective system for a comprehensive handover between nursing teams. There were set nursing teams, `A` and `B`, who worked twelve hour shifts. There was a fifteen minute handover period at the beginning and end of each shift. The nurse in charge would give a handover to the on-coming shift. There was a potential that staff only ever got a handover from the night staff. There was no opportunity for a comprehensive nursing handover and discussion about care and treatment during the day. Some staff told us that there was inconsistency between the set teams. Some patients told us that they had experienced inconsistent treatment and observed conflict between staff teams. We saw meeting minutes which also highlighted this concern.

There was a multi-disciplinary team (MDT) handover Monday – Friday 9 – 9.15am, for all MDT staff to attend. Staff also communicated by e-mail and a ward communication book. We saw daily handover documents used on Ferguson and Bradlaugh wards, although these were not

Requires improvement

Services for people with learning disabilities or autism

consistently completed for each day and varied in quality of information. For example, some entries stated `been settled`. Hawkins ward had a weekend handover sheet to update staff coming on duty on a Monday. Other communication forums such as Care Plan Update and ward round meetings took place on all the wards. We observed two MDT meetings and a Care Programme Approach (CPA) meeting. Staff listened to each other respectfully and discussed care needs appropriately.

We saw minutes from some of the clinical team meetings and saw that care needs, safeguarding and medication issues were discussed. Due to the complex needs of some of the patients, there were external agencies, such as NHS England and the Ministry of Justice involved in treatment and discharge plans. The staff told us that there was sometimes difficulty ensuring actions were taken in a timely manner, for example, transferring a patient who was not appropriately admitted onto a ward.

Are services for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

We observed little activity or interaction between staff and patients on the wards we visited. The exceptions where with the exception of Bradlaugh ward, where a healthy living fayre was taking place, and Harlestone, where patients were involved in OT activities.

Patients gave a varied view of how they were treated. Some patients told us that they were well cared for and they had no concerns about the staff. Some patients felt angry and frustrated by how they were treated, stating that staff did not listen to them and that they did not like how staff spoke to them. Some staff told us that they were concerned that the restrictive routines in place affected how they were able to care for people individually. For example, the emphasis to meet the 25 hour activity target took priority over what the individual might want to do.

The involvement of people in the care they receive

Patients were encouraged to attend their care management meetings. We saw that some patients were supported to complete a form to take in with them, or give to the MDT if they did not wish to attend. In the CPA meeting we observed, it did not appear that people were listening to the patient. We observed that sometimes clinicians used language that the person could not understand.

There was little evidence that patients or their carers were actively involved in writing or reviewing their care plans. Most patients we spoke with did not have a copy of their care plan and could not identify goals. Some patients were aware that they could request a copy. On Bradlaugh Ward the patients had copies of their care plans in their rooms but not in a format that they could understand. For example, one person had a written care plan but they were not literate. Hawkins ward staff advised us that people didn`t have copies in order to protect their personal information. None of the patients we spoke with had drawn up, or had a copy of, a health action plan.

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. We saw a report from Voiceability for July 2014, which showed that patients were contacting them regularly.

Each ward had weekly community meetings, with patients and staff. We saw meeting minutes from these. There were some support and engagement projects with the patients on the wards, from the patient experience team. We spoke with patient representatives, they told us that they felt listened to in meetings they attended.

Are services for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access, discharge and bed management

Referrals and admissions were accepted from other St Andrew's services and NHS or independent healthcare providers nationally. We were advised there was a

pre-admission assessment form which was completed for all patients. The patients were assessed by a consultant psychiatrist or senior nurse from the specific ward that they had been referred to.

Pathway bed management meetings took place on a weekly basis. We saw minutes for these meetings. There were some patients who were not on appropriate wards for their needs, and they had been there for over a year. For example, two patients on Bradlaugh, a rehabilitation ward, needed constant staff supervision and high levels of care. Staff told us that this had an impact on the ability of staff to promote the rehabilitative aspects of the ward for other patients.

The ward environment optimises recovery, comfort and dignity

Hawkins, Harlestone and Mackaness, were in newer facilities, which met low and medium secure standards. The facilities were single sex and adhered to safety, dignity and single sex guidance. The ward environment was adapted to meet the needs of people with a physical disability. For example, corridors were wide, there was lift access and disabled bathroom facilities. These wards had access to a designated space within the building for visitors who had children with them and rooms available for private meetings.

The other wards we visited were in an older part of the hospital. It had been acknowledged by St Andrew's and recorded in previous CQC inspections, that these wards were not suitable to meet patient needs. Several of the wards we visited across the service did not meet NHS England environment standards so were part of the organisation's project to upgrade wards to meet the standards required. Bradlaugh and Ferguson wards were due to be moved by January 2015 as part of this overall project. These wards were not accessible for people with significant physical disability, requiring wheelchair access. We saw there was visitor space and private rooms available away from communal areas.

Hawkins, Mackaness and Harlestone Wards had direct access to outside courtyard spaces. Bradlaugh and Ferguson Wards were on the upper floors, but had access to garden space in the grounds and a roof terrace smoking area. Patients could access outside space but this was dependant on their leave status, risk safety system level and the ward staffing numbers ability to facilitate their leave safely. We were told by staff and patients that staffing arrangements sometimes affected patient access to outside space.

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. We did not observe any patients doing so during our inspection. The wards had set times when drinks were provided, although patients could ask for drinks outside of these times. There were ward restrictions which limited patient access to hot drinks.

There were weekly meetings on each ward which the chefs attended to obtain feedback and comments from patients. We observed a meeting that took place on Mackaness ward. Patients told us that the food was generally quite good although there was a limited choice. The menu we saw had one hot meal option or sandwiches.

Ward policies and procedures minimise restrictions

Due to the complex needs of the people who use the service, some elements of choice and care were legally or therapeutically restricted. However, we saw that there were blanket restrictions in place as part of the overall ward routines. For example, cigarette breaks were to be taken hourly when staffing allowed, drinks were at set times, access to bedrooms was restricted to allocated times of the day, and there was no access to the kitchen or sensory rooms unless with an occupational therapist. The risk safety system levels also determined whether a person had a bedroom key or what a person could keep in their room. For example, level one meant that patients could only keep a few personal belongings. Some of these ward procedures were outlined in the ward operational policies.

There was a St Andrew`s service wide visitor's policy. This stated that visitors could only attend the wards after giving notice and with prior agreement from St Andrew's. This also applied to legal representatives and was irrespective of individual circumstances or risks. It was also in place on the wards which were not considered to be medium secure. In addition to the service wide visitor`s policy, visitors could also be restricted dependent on the risk safety system level the person was on.

Most of the patients on the wards we visited were detained under the Mental Health Act. We noted that Section 17

Requires improvement

Services for people with learning disabilities or autism

leave arrangements we looked at were linked to the generic risk safety system. For example, if someone changed risk safety system level, their right to access their Section 17 leave could be affected.

Meeting the needs of all people who use the service

The patients on the wards had varying levels of cognition and literacy. For many this meant that terminology needed to be simplified and presented in more basic and pictorial forms. We observed limited easy read signage or information displayed on the wards. All wards had Speech and Language Therapy input, educational support, advocacy and occupational therapy staff to support staff and patients in communication. However, we saw limited examples of patient forms and information that were clear and in easy to read format. For example, most patients were given copies of activity schedules which were complicated and difficult to understand.

The men`s service had a full time dietician who worked across all of the men's wards. There was a nutritional screening tool to generate referrals through to the dietician as required. The dietician held both individual and group sessions. We were advised that there was capacity to meet dietary requirements of religious and ethnic groups.

Listening to and learning from concerns and complaints

There was a complaints procedure, although we did not observe easy read information about this clearly displayed on the wards. 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 nineteen complaints across the mens' learning disability wards since January 2014. However, we saw examples of complaints which were not on this document. The Hawkins community meeting minutes showed that patients had requested that senior management attended to hear their concerns. It was not clear how this had been acted on, nothing was recorded and staff members we asked did not know.

Patients told us that they did not feel that their complaints were always listened to or acted on. Patients told us that they did not get always feedback from their complaints. For example, one person told us that they had complained about a bank staff member, they did not know what happened following this. Although, one patient also gave us an example of how their complaint had been resolved to their satisfaction.

Some staff members told us that the patients complained frequently. We saw there was a policy in place to manage `frequent complainers`. However, it was not clear how this was used at ward level to learn from people who made frequent complaints and manage individual issues appropriately. We were advised that complaints received on the wards were discussed in ward manager and patient safety meetings; where they would be reviewed to identify themes and share learning points across all services. Independent investigations were undertaken if complaints were `upheld`. However, most complaints were recorded as `not upheld`, if they had been resolved at a local level. This could mean that potential themes on the wards were not investigated appropriately. The provider confirmed all complaints are reviewed for learning these are discussed at the community, ward, service meetings, are included in the Quality Dashboard and form part of the reporting directly into the executive team on a weekly basis.

Are services for people with learning disabilities or autism well-led?

Requires improvement

Vision and Values

We were told that many of the governance processes were centrally administrated. For example, monitoring of staff training requirements, supervision and audits. The ward managers then followed up on ward level, as indicated in a centrally administered ward action plan. Some care and treatment processes were also centrally managed, for example arranging care programme approach (CPA) meetings, which meant that CPA reports could be written several weeks prior to the meeting taking place which might not include up to date information and there was little flexibility to change dates if required. We were told that many of these processes were administratively time consuming. Shift time direct care and governance activities were also largely centred on the minimum 25 hours a week ward activity schedule, rather than individual ward requirements.

There were recognised difficulties in ensuring that the wards had the correct staff skill mix for the patients' needs. There were regularly high numbers of bank and agency staff used across the wards. Ward managers were not able

to directly book staff. Staffing requirements were centrally managed through the site nursing bureau. Sometimes staff were moved between wards to help with their staffing arrangements.

Incident reporting and safeguarding processes were consistent across the wards. All serious untoward incidents (SUI`s) were reportedly discussed within the patient safety group and ward manager meetings and reviewed as required, determined on the severity of the incident. Data from incident and safeguarding reports was collated through both the local and provider wide Patient Safety Groups. We saw meeting minutes which reflected this.

Leadership, morale and staff engagement

Staff from across all disciplines told us that a lot of the care and treatment processes were centrally decided. Some staff told us they did not think that there was enough flexibility to work differently with different patient groups or individuals. Some staff did not feel engaged with service developments.

Most staff working directly on the wards 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 bank and agency staff in very challenging environments. Staff were leaving substantive positions to become bank staff. Some staff had raised concern about the inconsistent team working between set `A` and `B` nursing teams on some wards. Some allied health staff were concerned about increased workload and impact on care delivery, as a result of new ways of working being introduced. The staff we spoke with identified that overall morale and team performance had been negatively affected over the past year.

Staff generally felt able to raise concerns with their immediate line manager or senior nurses. The managers we spoke with, told us that they felt that their immediate service manager was supportive and listened to concerns that they raised.

Commitment to quality improvement and innovation

St Andrew's had recently introduced a dashboard system which enabled them to monitor quality and performance at ward level. Senior managers reported that there were a number of forums, such as the patient safety group, clinical governance group, and a quality and compliance group which all regularly met to monitor quality and performance, as well as identifying trends from incident reporting. We saw meeting minutes from some of the groups, which showed information was shared and actions agreed.

We were advised that HONOS was used as an outcome measurement, and Makeness Wards had recently participated in the overall William Wake House `self` and `peer-review` parts of the assessment organised by Quality Network assessment for Forensic Mental Health Services.

Good

Other specialist services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Neuropsychiatry services

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

- Tallis ward which was an admission ward for 15 men with specialist neuropsychiatric conditions.
- Tavener ward which was an active rehabilitation ward for up to 16 men with specialist neuropsychiatric conditions.
- Althorp ward which was a slow stream rehabilitation ward for up to 19 men with specialist neuropsychiatric conditions.
- Berkeley Close and Berkeley Lodge which were rehabilitation wards for 29 and 6 people with neuropsychiatric conditions respectively.
  The Neuropsychiatry Services are located in Northampton. We visited five ward areas.

Summary of findings

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

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

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

Good

Other specialist services

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

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

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

Are other specialist services safe?

Good

Safe and clean ward environment

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

Althorp ward and Tallis ward had identified blind spots which were managed by increased staff observation and awareness. We checked seclusion facilities on the wards we visited. We found they offered a safe environment and met the guidelines stated in the Mental Health Act (1983) code of practice. Most wards had access to resuscitation equipment and emergency medication. However, these facilities were shared between wards and they were not present on Althorp ward.

Safe staffing

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

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

On Tallis ward however, five staff members identified that they felt there was an issue related to staffing numbers and understanding of needs of people on the ward. We looked at the establishment numbers for Tallis ward and saw that there had been an increase in the staffing levels prior to our

inspection visit. In figures provided to us, we saw that there was 1.1 WTE (working time equivalent) vacancy at band 2 level (for a healthcare assistant) and 1.3 WTE vacancy at band 5 (qualified nurse) level.

We looked at numbers of sessions cancelled on Tallis ward where the reasons given were that staff were on leave, unavailable or were in meetings over July and August. As this information was collated at an individual level we looked at the figures for four people chosen randomly and found that for two months, sessions which included gym, cooking sessions and walks had been cancelled for 25 hours, 24 hours, 18 hours and 15.5 hours. Comparing this to Tavener ward, we saw over the same period that for four people activities had been cancelled for 5 hours for three people and 2 hours for one person. This meant that for people on Tallis ward there was a risk that lack of availability of staffing had led to a poorer experience of activities.

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

Assessing and managing risk to patients and staff

On all the wards we visited, we checked risk assessment information for people who used the services. We looked at 27 records on the five wards we visited. We found that risk assessments were completed comprehensively and were up to date with current information. Information about risk was gathered on admission and frequently updated by multidisciplinary teams. We also checked medicines management by looking at the storage, dispensing and recording of medicines. All the records we checked were complete and the systems in place to manage medicines were safe.

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

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

Reporting incidents and learning from when things go wrong

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

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

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

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

Good

Other specialist services

Are other specialist services effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care

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

Best practice in treatment and care

People working in the neuropsychiatry services had an understanding of current relevant NICE guidelines and we saw that information was discussed at the management level to ensure that policies on the wards reflected these guidelines. Consultants that we spoke with were aware of the specific prescribing guidelines.

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

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

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

Skilled staff to deliver care

We found that qualified staff received supervision monthly. These sessions were recorded and were audited by ward managers and senior managers. Staff had received annual appraisals to ensure that their professional development was maintained. Health care assistants attended regular weekly group supervision sessions.

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

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

Multi-disciplinary teams on the wards consisted of nursing staff, medical staff, health care assistants, psychologists, occupational therapists, technical instructors and social

Good

Other specialist services

workers. On some wards where the rehabilitation focus was at a specific level, there was access to support from physiotherapists, speech and language therapists. Pharmacists regularly visited the wards.

Multi-disciplinary and inter-agency team work

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

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

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

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

Adherence to the MHA and the MHA Code of Practice

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

Good practice in applying the MCA

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

Are other specialist services caring?

Good

Kindness, dignity, respect and support

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

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

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

Good

Other specialist services

contained cigarettes where staff sat away from the sofas and chairs where people who used the service sat. During the mid-afternoon, people were watching the television and sleeping without much evidence of stimulation.

The involvement of people in the care they receive

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

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

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

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

Are other specialist services responsive to people's needs?

(for example, to feedback?)

Good

Access, discharge and bed management

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

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

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

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

There had been an increase in the group of people with Huntington's disease on Tallis ward which had affected the clinical risks on the ward and this was raised as a concern. This had been identified at the clinical advisory group

meeting for neuropsychiatry as an issue which needed to be addressed and the need for further training within the staff group had been identified as an action. We saw that there had been an increase in the staffing levels on Tallis ward due to some of the concerns raised. There were plans to convert an unused room on the ward into a second lounge area to allow people more different spaces on the ward. This meant some changes were being made to the care provided to increase the responsiveness of the setting.

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

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

The ward environment optimises recovery, comfort and dignity

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

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

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

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

Ward policies and procedures minimise restrictions

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

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

Meeting the needs of all people who use the service

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

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

In the patient survey for St Andrew's we saw that people within neuropsychiatry services had the lowest answer for

Good

Other specialist services

the question "Do you feel that your spirituality needs have been addressed?" where 46.4% of 67 people who responded within the service answered yes. This was identified as an issue which needed to be addressed following the survey. However, those people we spoke with told us that they felt their needs were being met in relation to their culture and religion. We saw that there was information on wards about access to multi-faith chaplaincy services.

Listening to and learning from concerns and complaints

Wards had information about how to make complaints on display. Most people we spoke with told us that they knew how to make complaints. We looked at the complaints which had been made within the service. We saw that there was a central complaints policy. Informal concerns were generally not logged. However, an action plan was developed from the annual survey where people were able to feedback information about the care provided to them.

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

Are other specialist services well-led?

Good

Vision and values

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

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

Good governance

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

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

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

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

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

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

Leadership, morale and staff engagement

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

Good

Other specialist services

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

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

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

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

Commitment to quality improvement and innovation

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

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

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

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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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	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 child and adolescent mental health service. The service had not followed best practice in relation to people have positive behaviour support plans where appropriate. 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. In the learning disability service. Patient care and risk was not assessed, planned and managed 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. 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 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 In the forensic services the Code of Practice Mental Health Act 1983 was not always being followed.

This section is primarily information for the provider

Compliance actions

Sitwell ward was not consistently documenting patients review of restraint

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

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

In the older persons service

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.

Regulation 9 (1) (b) (i) (ii) (iii) (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **How the Regulation was not being met:** In the child and adolescent mental health service and learning disability service. Some staff did not have training and understanding about safeguarding. There were not clear systems to ensure that agency and bank staff were aware of the care needs of people. Restraint care plans and techniques required improvement. The hospital policies and practices do not meet current best practices. The methods of restraint used can place people at risk of harm. The service does not have a robust system in place to learn from incidents and ensure that the risk of harm is minimised. Seclusion facilities were being routinely used for de-escalation and time out and not recorded as seclusion.

This section is primarily information for the provider

Compliance actions

Regulation 11 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

How the Regulation was not being met:

Across areas of the service there was inadequate skill mix and deployment of staff to always meet the therapeutic needs of patients.

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

We found that there were not always enough members of suitably skilled and experiences staff to care for people safely.

There was high use of agency and bank 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.

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

Some staff did not have training and understanding about safeguarding

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

Regulation 22