Good

# Birmingham and Solihull Mental Health NHS Trust

# Long stay/forensic/secure services

## Quality Report

50 Summer Hill Road
Birmingham
B1 2RB
Tel: 0121 301 2000
Website: www.bsmhft.nhs.uk

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## Locations inspected

| Name of CQC registered location | Location ID | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| Reaside | RXT64 | Men's Service: Severn, Avon, Blyth, Kennett, Dove wards, Swift, Holyhill, Trent wards and Hillis Lodge were not visited at this inspection. | B45 9BE |
| Ardenleigh | RXT05 | Women's Service: Gaskell HDU, Gaskell and Baker wards. Child and Adolescent Mental Health Services(CAMHS), Armstrong and Johnson Wards, Centre for Learning | B25 9SA |
| Little Bromwich Centre | RXT37 | The Tamarind Centre, Men's Service: Sycamore, Lobelia, Myrtle, Hibiscus, Acacia, Cedar and Laurel wards | B10 9JH |

# Summary of findings

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

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

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

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

| | |
|---|---|
| Overall rating for long stay/forensic/ secure services | Good |
| Are long stay/forensic/secure services safe? | Good |
| Are long stay/forensic/secure services caring? | Good |
| Are long stay/forensic/secure services effective? | Good |
| Are long stay/forensic/secure services responsive? | Good |
| Are long stay/forensic/secure services well-led? | Good |

**Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

# Summary of findings

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# Summary of findings

## Overall summary

Forensic/secure services are based on three hospital sites at Reaside, Ardenleigh and Little Bromwich Centre (The Tamarind Centre). They are purpose-built facilities and provide inpatient mental health services for adults aged between 18 – 65 years in conditions of medium security.

Staff understood how to keep people safe and how to report any issues of concern. We found staff reported incidents/accidents and there was a system in place for reviewing and learning from them to prevent them happening again. There were systems for maintaining the health and safety for people, staff and the ward environment.

There were systems in place to ensure an effective service. Surveys and audits measured the quality and effectiveness of systems. Staff worked with different teams within the service to meet people's needs. We also identified good examples of collaborative working with stakeholders and other partners.

The services provided were caring. This was confirmed by our observations and discussions with staff during the inspection. Most people told us that staff were approachable and supportive.

The services provided were responsive. We noted some good examples of responsive and person-centred care during the inspection. There was an effective complaints management system in place. The site was being developed in response to people's needs.

The services provided were well-led. We saw that local leadership was proactive and led to effective service delivery. Staff told us that they felt supported.

# Summary of findings

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

**Are services safe?**

Good

Staff understood how to keep people safe and how to report any issues of concern. We found that staff reported incidents/accidents and there was a system in place for reviewing and learning from them to prevent them happening again. There were systems for maintaining the health and safety for people, staff and the ward environment.

We found comprehensive risk assessment systems of people's physical and mental health needs. The opening of The Tamarind Centre affected staff resources across sites and the provider had developed systems to track the impact of this and reduce the risks.

**Are services effective?**

Good

Staff worked with different teams within the service to meet people's needs. We also identified good examples of collaborative working with stakeholders and other partners. For example links were made with Bourneville College and plans were being made to develop a Recovery college.

The provider measured the effectiveness of their service, such as through the use of peer and self-reviews outcome tools and audits. Across sites we had mixed feedback about the availability of individual activities and systems were being developed to monitor this more effectively. The provider's seclusion policy referred to 'extra care' suites being used, however we noted that long term segregation was not. This was in line with the trust's policy and procedures.

**Are services caring?**

Good

Most people told us that staff were approachable and gave them support, and staff demonstrated this. The provider had systems to encourage people to be involved in their assessment, care planning and reviews, through the use of recovery tools such as 'My Shared Pathway' and SCALE.

**Are services responsive to people's needs?**

Good

We saw evidence in people's care and treatment records of how the service had reviewed and amended treatments in order to meet their changing assessed needs. We reviewed some good examples of responsive and person-centred care during the inspection. There was an effective complaints management system in place. There was evidence of site developments to respond to people's needs.

# Summary of findings

**Are services well-led?**

Good

There was a range of ways that the provider gave information to staff and people about their service. The provider had a governance framework in place; however, not all staff were able to explain this, for example relating to safeguarding systems.

Staff reported support from their line managers. They told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. People and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys.

# Summary of findings

## Background to the service

We reviewed the last Mental Health Act 1983 monitoring visit reports and previous Care Quality Commission inspection reports for these services and the subsequent action plan responses provided by the trust. There were no outstanding compliance actions in relation to these services. These helped to inform our inspection plan.

Forensic/secure services are based on three hospital sites at Reaside, Ardenleigh and Little Bromwich Centre (The Tamarind Centre). They are purpose-built facilities and provide inpatient mental health services for adults aged between 18 – 65 years in conditions of medium security.

Ardenleigh provides Women's and Child and Adolescent Mental Health Services (CAMHS). There is also a Centre for Learning on site.

Services for men are provided at Reaside and The Tamarind Centre. A separate low secure unit is based at Hillis Lodge. People are always detained under the Mental Health Act 1983.

However where there might be informal people using the service; there were signs up informing these people of their rights to leave at any time and how this was facilitated by staff.

People cannot freely access or leave the building and wards as doors are locked and there are 'airlock' features. There are intensive care, acute and rehabilitation wards. A forensic community service provides support to people moving from inpatient to community settings.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Peter Jarrett, Consultant Psychiatrist, Oxleas NHS Foundation Trust

**Team Leader:** Julie Meikle, Head of Hospital Inspections (Mental Health), Care Quality Commission

The team that inspected this service included a CQC inspector and a variety of specialists including an Expert by Experience (someone who had personal experience of the services inspected), Social Workers/Approved Mental Health Practitioners (AMHPS), Clinical and Forensic Psychologists and a Consultant Psychiatrist.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit to the service on 13, 14 and 15 May 2014.

During the visit we observed how people were being cared for. We reviewed care or treatment records of people who use services. We met with people who use services who shared their views and experiences of the service. We talked with a range of front line staff such as doctors, nurses, psychologists, occupational therapists,

# Summary of findings

service user development team workers, social workers. We also attended some ward community meetings, a ward and youth focus group and a patient council meeting. This assisted the Care Quality Commission to obtain a view of the experiences of people who used this service.

We requested and received some additional information from the provider relating to the five domains inspected.

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

We spoke with people who used these services provided by this trust through focus groups, attendance at daily community meetings, patient council meetings and individual conversations with people. We reviewed the provider's quality monitoring systems such as ward inpatient score cards, nursing dashboards and a sample of ward community and patient council meeting minutes across the sites. We also looked at some Service User Development Team reports. This was to enable the Care Quality Commission to obtain the views of people who had used this service. We requested further information relating to secure services and this was provided by the trust.

The feedback showed us that most people felt safe in the service. Most people told us that the service was caring and they could approach staff if they had any issues or concerns. We saw that individuals were encouraged to be involved in their care and treatment and had the opportunity to discuss these with their care teams.

We noted that the provider had received some feedback about access to activities and the quality of food provided. Several people also gave us feedback on these areas during our visit.

Birmingham and Solihull Mental Health NHS Trust

# Long stay/forensic/secure servicesLong Stay/Forensic/ Secure Services

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Men's Service: Severn, Avon, Blyth, Kennett, Dove wards, Swift, Holyhill, Trent wards and Hillis Lodge were not visited at this inspection. | Reaside |
| Women's Service -Gaskell HDU, Gaskell and Baker wards. Child and Adolescent Mental Health Services(CAMHS), Armstrong and Johnson Wards, Centre for Learning | Ardenleigh |
| The Tamarind Centre, Men's Service: Sycamore, Lobelia, Myrtle, Hibiscus, Acacia, Cedar and Laurel wards | Little Bromwich Centre (The Tamarind Centre) |

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We checked some care planning records and found evidence of people being provided with appropriate, timely information about their legal rights in relation to the detention under the Mental Health Act 1983.We found that detention papers were scanned onto the electronic patient record, including admission papers. We were advised that there were mental health administrators on site and there was a system to ensure that documents are scrutinised. We saw that any rectifiable errors identified had been corrected. Those training records seen showed us that staff had received training on the Act.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

People we met were detained under the Mental Health Act 1983 and therefore were not subject to Deprivation of Liberty Safeguards.

We found that provider had systems in place for assessing people's mental capacity to make decisions regarding their care and treatment. We found there were additional assessments on the Integrated care Record (ICR), electronic patient record system to be completed where there were additional concerns about a person's mental capacity to make decisions. We mostly saw they were completed for assessing people's capacity to consent to taking their medication. The provider had systems in place for recording and reviewing any restraint techniques carried out with people using the service. Those training records seen showed us that staff were receiving training on the Mental Capacity Act.

Good

# Are services safe?

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

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

## Summary of findings

Staff understood how to keep people safe and how to report any issues of concern. We found that staff reported incidents/accidents and there was a system in place for reviewing and learning from them to prevent them happening again. There were systems for maintaining the health and safety for people, staff and the ward environment.

We found comprehensive risk assessment systems of people's physical and mental health needs. The opening of The Tamarind Centre affected staff resources across sites and the provider had developed systems to track the impact of this and reduce the risks.

## Our findings

### Reaside

#### Track record on safety

We saw that the trust had systems in place for the recording, monitoring and reviewing of safety data from a range of sources such as feedback, incidents, reviews, audits and surveys and to disseminate learning from incidents across the trust. For example, at Reaside the monthly 'Risk, Security and Health' and 'Clinical Governance' meetings took place and risk registers were reviewed. There were opportunities for cross unit learning through joint clinical governance meeting with The Tamarind Centre staff. However the trust may find it useful to note that the risk security and health meeting minutes for February and April 2014 did not always detail the actions required and timeframe. Minutes did not detail if safeguarding issues were reviewed at this, or the clinical governance meeting, and it was unclear how this was being monitored. We saw that this was a standard agenda discussion item at Ardenleigh.

Staff across sites described and showed us incident reporting on their electronic record 'Eclipse', where at ward and team level, themes and improvements could be tracked. A summary of data, themes and numbers of incidents was transferred onto a data system called 'the black hole' which senior staff had access to review their wards performance.

#### Learning from incidents and improving safety standards

Staff gave us examples of learning from lessons on their ward and across the unit and trust. Kennett Ward staff told us of an incident where a person was suspected to have smoked drugs. They referred to the trust's search and drug testing policy and procedures. They explained the investigation and management at ward level regarding a process of room searches and drug testing. Additionally there were trained dogs that could be brought to the ward to locate drugs if required. Posters across sites informed people about 'Danny the dog'. Staff gave another example of learning from incident at another unit which had been investigated and the trust had produced a risk alert. There was a system for discussing this with staff, along with the relevant policy, within a specified timeframe. Staff confirmed this had taken place.

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

Staff understood the need to report any safeguarding concerns and discussed them with the clinical team. The person's care plans and risk assessment were updated and the incident logged on 'Eclipse'. Examples were given of moving people across wards and sites to keep them safe if there had been an issue with another person on their ward and of preventing bullying or assaults on the wards. However some nursing staff we spoke with for example on Kennet and Dove Wards were not clear on the local reporting mechanisms via the local authority or the systems for investigating and reviewing safeguarding issues further within the trust. Staffs knew about the trust safeguarding lead but were unable to explain their role. Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager.

Staff reported induction training regarding relational security and managing safe boundaries with people.

Good

# Are services safe?

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### Assessing and monitoring safety and risk

'See, Think, Act' relational security handbooks were available for staff along with posters across secure services. Relational, procedural and physical security had been assessed and managed in various ways. Environmental assessments such as ligature audits were routinely undertaken. We found that where we observed items such as televisions and games consoles' with wires that these had been identified as potential risks and plans were identified to manage them. We found two ward kitchens, with sink taps, which were open so people could enter. However, Blythe Ward's assessment did not highlight this risk. This was brought to the attention of staff during the inspection. Dove Ward's assessment had and stated the risk was managed by staff observations and risk assessed for people's access. Wards were undergoing refurbishment to reduce risk of self-harm to people such as anti-ligature communal bathrooms and bedrooms. We found that risk assessments routinely took place to determine the level of security people needed for off ward and community leave. Examples of positive risk taking were assessments for people to have access to bedroom keys giving them greater access to their room.

Additional risk assessment areas included those which took place before people received visits. Agreed visits took place in specific areas with staff support as required. A system was in place to restrict items coming on to the unit that may pose a risk. Staff assessed and supervised people's access to sharp objects such as razors.

A security team was responsible for managing premises security across sites with systems in place to monitor safety in the building and perimeter safety. For example, sensors were in place to monitor people's access to roofs. Staff held personal alarms to call support from other staff. A trust on-call system operated for staff to contact senior managers in for support and guidance.

### Understanding and management of foreseeable risks

Staff reported some staffing challenges due to the opening of the Tamarind Centre in 2012 as some staff moved across. New staff were recruited and additionally bank and agency staff were used in the interim and we saw an action plan developed to track, monitor and address risk areas. Avon, Blythe and Kennet staff told us there were seven clinical teams and meetings did not always give people appointment times. This affected staff resources as they could be called to attend two meetings at the same time. An example was given that occasionally one staff member carried both controlled drugs cupboard and medication cupboard keys which was not usual procedure. Senior staff told us there should be systems to prevent this and that this would be reviewed.

## Ardenleigh

### Track record on safety

A modern matron told us they received a separate report sent to them, with data on incident reporting, and they forwarded this to the unit managers with pivot table/ dashboards. These were reviewed at fortnightly senior nursing meetings. They gave an example of how two wards at Ardenleigh had been identified as having more incidents relating to medication administration than some others across the trust. Analysis had been undertaken and an action plan was developed to reduce the number of incidents. This had identified that very few medication dose errors were occurring but other issues also identified such as record keeping, storage and delivery issues. There was a system for two nurses, across all sites, to administer medication to reduce risk occurring and pharmacy audits took place. If there was a staff recording error as part of ensuring competence they may be resent for 'medi code' training. Staff had given the matron positive feedback on this training and were able to clarify issues of practice with them. We learnt that pharmacy audits took place including The National Prescribing Observatory for Mental Health (POMH-UK) which aims to help specialist mental health trusts improve their prescribing practice.

Monthly clinical risk and security meetings were held. We saw that there was a calendar of audits which included auditing staff knowledge and safeguarding referrals. The service delivery and business meeting minutes dated February 2014 demonstrated that governance systems on safeguarding children referrals systems were being reviewed to ensure effectiveness.

### Learning from incidents and improving safety standards

All incidences are reported via a trust wide electronic incident reporting system and analysed at a local and wider trust wide level. The trust produced a "lessons learnt" bulletin on a regular basis that was posted on the trust's intranet as well as to all trust email accounts. Staff were

Good

# Are services safe?

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informed through a variety of meetings and/or posters of any emerging themes or lessons. We found that the lessons learned trust briefing, as well as safety posters, were displayed in offices across the sites inspected.

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

Staff awareness of safeguarding reporting systems included greater awareness of local authority reporting procedures. We saw that there was a safeguarding, tracking and audit log in the CAMHS unit for monitoring incidents and outcomes. On Gaskell Ward a discrepancy in data was detected and 'Eclipse' reported safeguarding incident information was not reflected on the 'back hole' systems. It showed one safeguarding incident in 18 months whereas we identified with the unit manager four incidents had been reported. Staff evidenced that actions had been taken to address the safeguarding issues and that there was a system at ward level to monitor safeguarding themes.

Across CAMHS and women's service there were systems to establish people 'level' of risk. A member of staff told us their work was to "keep people safe, but active." We found there were systems for assessing environmental risks. There were systems for managing security similar to Reaside. For example games controllers in the CAMHS were wireless and cables were kept secure to prevent ligatures. In contrast we found loose batteries in a communal area on Armstrong Ward and we felt this could pose a risk to people. This concern was brought to the attention of ward based staff during the inspection. Staff told us communal areas was monitored. CAMHS staff carried out risk assessment to ensure young people only had access to age appropriate games, films and music.

On Gaskell Ward staff gave examples of where they had assessed the risks to people, considered the need for observations and the balance between respecting people's privacy and ensuring safety. Systems were in place across sites to arrange secure video links with court hearings, where it had been assessed that the risks were too high for them to safely attend in person.

### Understanding and management of foreseeable risks

Staff and young people in the CAMHS service were due to move to a purpose built building, furnished according to the latest standards. Staff had planned a sleepover to further risk assess and evaluate the facilities to ensure it would be safe and suitable for young people to move to.

The clinical risk and security meeting minutes dated January 2014 highlighted that there was a risk of staff shortage on Baker Ward in the women's service. We looked at what action had been taken from the provider. We saw from other meeting minutes that actions to arrange additional staffing had taken place and this indicated that these risks were being managed.

In October and November 2013 several complaints were received from people on Baker and Gaskell Wards regarding insufficient staff for activities/leave and these were upheld. Information from the trust reported an improvement in the use of core ward based staff. This showed us that in January 2014, 992 shifts were covered by bank or agency staff and 103 shifts were not covered, a reduction since December 2013. We saw a further reduction in February 2014 with usage reduced to 777 shifts with 69 not covered.

We noted that a high proportion of staff (855 out of 4,000 staff) worked in secure services and it had been identified that the opening of Tamarind Ward had affected staffing across the sites. Staff did not report significant problems with staffing when we visited. May 2014 resident council minutes identified that staff vacancies have been filled, and were now in post. Staff referred to bank and agency use for example to respond flexibly when people's observation levels had increased, and where possible ensuring regular staff who knew the people they worked with to reduce risks. Staffing levels were displayed on wards across sites indicating when staff were either bank or agency. We noted the Chief Executive Officer had met people at Ardenleigh in May 2014 and staffing and activities were discussed as issues. Actions from that meeting were to put a measure in place to capture how staffing numbers and skills affect people's experience.

During our visit people on Gaskell Ward raised concerns that unit based activities were not taking place. We requested and received some information relating to planned and cancelled activities however the data we received did not indicate the number of sessions cancelled due to staffing issues and the impact could not be established.

## The Tamarind Centre

### Track record on safety

Staff used trust wide systems for reporting incidents. Those risk and security meeting minutes dated from February 2014 to April 2014 showed us that safety and security issues

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were reviewed and discussed. However compared with other sites, the Tamarind Centre minutes did not always detail the nature of the risk, actions and learning points from incidents to be shared with staff with the actions required by staff and timescales. For example March minutes identified that two incidents were 'frequently reported' and 'searches and staffing concerns' but there were no further details. We found evidence of infection control audits taking place for example on Hibiscus.

### Learning from incidents and improving safety standards

We saw learning from incidents posters and briefings developed for the wards. Some spoke about debrief meetings following incidents and the need to maintain professional boundaries with people. Myrtle and Acacia Ward staff gave us examples of learning from incidents such as ensuring they checked that emails had the correct address following an information governance incident elsewhere in the trust. Systems were in place for checking medication administration. We witnessed an example of incident reporting on Acacia Ward and a staff member investigating and discussing the issue with ward staff.

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

We received some positive feedback from people on Cedar Ward who commented that they felt safe on the ward. We gained mixed feedback regarding staff awareness of safeguarding reporting procedures on Hibiscus Acacia and Lobelia Wards. Most staff were aware of the need to report any safeguarding concerns. However, they were less able to explain the next step such as when things were investigated or not. We saw an example for where a safeguarding matter had been raised for one person and the matter investigated and actions taken.

### Assessing and monitoring safety and risk

We saw that there were clear systems in place for the recording and monitoring of seclusion and restraint. A person on Laurel Ward confirmed that staff had undertaken checks to keep them safe and they had felt safe.

We found, across the sites, that there were systems for assessing and developing care plans for individual risks to people using standardised risk assessment tools, such as HCR20 -Historical Clinical Risk Management, SAPROF -a violence risk assessment tool, specifically developed for the assessment of protective factors for adult offenders. However we identified on Lobelia Ward that four people's HCR20 assessments had gaps in the information. One had not been updated and was completed at a previous hospital, for two people information was duplicated from the previous assessment. For another there was a discrepancy with the coding. We found evidence in some care plan records for Myrtle and Lobelia Wards that risks identified were not fully reflected in the care plan needs.

### Understanding and management of foreseeable risks

Several staff and people gave us positive feedback on the environment. In contrast with Reaside and Ardenleigh, the building was less than two years old and had been designed and furnished with reference to the latest guidance for medium secure sites.

We observed that there were clearer lines of sight to ensure staff could observe people more efficiently. We noted that across sites staff had systems for assessing the level of observation that people required and carrying out checks and recording them.

# Are services effective?

Good

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

## Summary of findings

Staff worked with different teams within the service to meet people's needs. We also identified good examples of collaborative working with stakeholders and other partners. For example links were made with Bourneville College and plans were being made to develop a Recovery college.

The provider measured the effectiveness of their service, such as through the use of peer and self-reviews outcome tools and audits. Across sites we had mixed feedback about the availability of individual activities and systems were being developed to monitor this more effectively. We found that the provider's seclusion policy referred to 'extra care' suites being used, however long term segregation was not.

## Our findings

### Reaside

#### Assessment and delivery of care and treatment

We found that the trust had systems and processes in place to ensure multi-disciplinary assessment prior to admission. People, who were newly admitted, had an initial risk assessment and subsequent treatment plan. The provider had a system for people to have care plan plans developed using the care programme approach (CPA) and an inpatient care plan. This was a particular way of assessing, planning and reviewing someone's mental health care needs.

Across all sites we noted that inpatient care plans we saw used more service user friendly language, using people's words, whereas their CPA care plans were generally more formal. Staff told us that work was being undertaken to ensure they also reflected the SCALE model and audits were undertaken to ensure quality and consistency across wards. Clinical governance team meeting minutes confirmed this.

Systems were in place to respond to people's physical health needs. We saw examples of comprehensive physical health assessments. Lead nurses for physical health care were identified for wards and unit meetings took place to review and monitor issues. A GP and practice nurse visited the unit weekly to review reported health issues. Other professionals such as a physiotherapist, optician, dietician, podiatry, dentist and diabetic nurse were available. Systems were in place for onsite medical emergencies. Joint working between staff from secure services and the local acute general hospital was taking place to develop guidance and procedures for when people required physical health care treatment. This looked at managing security and maintaining the person's dignity. This ensured effective communication regarding people and staff needs during the visit and admission.

An advocacy service was available on site and information on the service displayed. People told us they had access to fresh air. People reported opportunities to learn or maintain their skills and independence to the level they felt they were able to manage. For example, people could carry out laundry, kept their room tidy and undertook money management. Kitchens were available across sites for people to make drinks independently or with staff support as required.

#### Outcomes for people using services

We found across all sites that staff used the SCALE model where goals are set each stage of the model to deliver individual or group intervention. Additionally staff encouraged people to use the 'My Shared Pathway' (MSP) booklets. MSP is part of the National Secure Services QIPP Programme. It developed a recovery approach to identifying and achieving outcomes and aimed to streamline the present pathway for service users in secure services. People identified their needs with staff and outcomes they wanted to achieve with timelines. This influenced their care plans.

There were systems for monitoring bed occupancy and delayed discharges across all site, such as weekly bed meetings. Additionally patient surveys and nursing metrics identified areas for improvement. Nursing Quality Metrics (NQMs) included the results of the nursing audits and patient experience questionnaire. Outcomes for people was also assessed through use of the Health of the Nation Outcome Score (HoNOS) secure.

#### Staff, equipment and facilities

Staff spoke about multi-disciplinary working across wards. We received positive feedback from staff on Severn Ward (intensive care unit) where there was one multi-disciplinary team. Staff we spoke with gave positive feedback regarding other ward team's engagement in meetings to ensure consistency when moving people between services.

# Are services effective?

Good

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

There were systems in place at all sites where unit managers could see the staffing levels on other wards across each ward. This helped staff to identify and cover any shortfalls. Staff across wards reported use of regular bank staff and minimal use of agency.

We received positive feedback about staff meeting people's spiritual needs on Kennet and Dove Ward. Where people were assessed as able to have leave off the ward they could access the multi faith room or arrangements would be made for a spiritual advisor to visit the ward or by telephone.

There were a range of facilities on the unit such as an OT activity department with woodwork, gym, art, gardening and kitchen areas. On Severn Ward there were gym and activity facilities where people leave the ward. There was in-door and outside space for recreation and people had opportunities for fresh air daily.

### Mental Health Act (MHA)

We checked some people's care planning records and found evidence of people being provided with appropriate, timely information about their legal rights in relation to the detention under the Mental Health Act 1983.We found that detention papers were scanned onto the electronic patient record, including admission papers. We were advised that there were mental health administrators on site and there was a system to ensure that documents were scrutinised. For one person we found one occasion where the Approved Mental Health Act Health Professional (AMHP) application for detention papers had two different handwritings and we brought it to the attention of staff to look into.

## Ardenleigh

### Assessment and delivery of care and treatment

The provider had systems for assessment and care planning as identified at Reaside. In the CAMHS unit an example was given where staff had identified the need for some people to have pictorial care plans where people had difficulties reading or writing and this was being piloted. We saw an example of a care plan with a traffic light system of different colour cards to express how they were feeling and for staff to respond to. We saw across other wards staff had boards with information about people's assessments for staff to refer to at a glance. For example, Gaskell Ward had a system for monitoring information about people such as when they had been informed of their legal rights and the last keyworker session. A staff member told us that an audit tool was being developed to monitor people's care plans. Risk stages identified for Gaskell Ward and the HDU. Each stage detailed the level of risk a person might pose, the level of observation required. The levels were changed according to the increase or decrease in risk for the person as they progressed.

### Outcomes for people using services

As previously reported for Reaside, we also found the use of outcome measures such as use of the SCALE model and 'My Shared Pathway' (MSP) booklets at Ardenleigh Health of the Nation Outcome Score (HoNOS) secure.

Quality Network peer and self-assessment reviews had taken place for CAMHS and the women's service in 2013. We noted that strengths for the CAMHS service included staffing, training and facilities. Giving more positive feedback to families was commented on. We found since then action had been taken to develop systems for provision family regular reports. Additionally a 'you tube' video had been developed for people and visits giving detail about the unit and this had received positive feedback from people and families. A suggested action in the women's service related to recent staff changes and working with people to access off-ward activities where appropriate. Also some actions to improve the seclusion area. Strengths commented on included physical health services and the range of activities and initiatives for people.

Following the women's service Quality Network review 2012, the 2013 review identified that that carer involvement had improved and there was now a divisional families and friends meeting, with carer representation. We found reference to a family/ carers event where staff gave, 'You've said we've done" feedback.

### Staff, equipment and facilities

Ardenleigh had indoor areas such as a communal sports hall, multi-gym, swimming pool and games room and information technology areas. Outdoor areas included an all-weather pitch, an orchard area and 'Zen' garden.

Angelou is the designated therapy resource area for the women's service, with individual, group, art, cooking and IT resources available. Baker had a small group room. There was an onsite shop. People could access complimentary therapies. The matron advised that a service providing vocational support to people to learn future skills had recently stopped. Occupational therapy services were working in partnership with Bourneville College to offer a

# Are services effective?

Good

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

14 week accredited programme for people such as 'The Get Ready for Employment and Training' course where people developed skills and knowledge needed for future employment, training or volunteering. For example learning how to complete job applications and CVs.

Systems were in place across the sites for staff to support people to get shopping when they did not have community leave and the computer could be used to browse items

People and staff reported spiritual and cultural needs were met through access to a multi faith room or contact with the spiritually team such as an Imam or chaplain. People told us they could have halal or Caribbean food and there were flexible meal times during Ramadan.

Staff and people were planning to develop a Recovery college across the sites. Recovery colleges are identified through 'The Implementing Recovery Through Organisational Change' (ImROC) the aim was to deliver comprehensive, peer-led education and training programmes within mental health services.

Ardenleigh had a centre for learning. Young people using the CAMHS service attend the James Brindley school on site which is regulated by Ofsted (Office for Standards in Education, Children's Services and Skills). This enabled them to continue their education and learning.

Staff told us that there were plans to move the CAMHS service into a new building within the month. This plan had been developed to refurbish the existing building to further develop the specialist women services.

We looked at seclusion records and facilities across the sites. We found that the trust's current and draft seclusion policies referenced (NICE) National Institute for Clinical Excellence clinical guidelines and gave staff guidance regarding assessment, records and reviews required and guidance when using rapid tranquilisation. We noted the policy referred to 'extra care' areas but did not reference long term segregation. We noted use of this for example on Gaskell Ward where people were placed in a locked area away from other people when they posed a greater risk to themselves or others. They received specific staff observation and were not restricted to being in one room.

The Mental Health Act code of practice confirmed that hospitals proposing to allow longer-term segregation should have a policy in place setting out when it was to be used and how it was to be kept under review. A person using the extra care service gave us positive feedback about the care saying they preferred it to the High Dependency Unit and felt they were moving through the care pathway.

There were systems for monitoring staff access to supervision and appraisals. For example on Armstrong Ward we saw that clinical supervision was not recorded until after December 2013, whereas management supervision was. The trust had systems to highlight when staff appraisals were due, to establish any professional development needs.

### Multi-disciplinary working

Staff reported positive working relationships between multi-disciplines. They told us that they worked with different clinical teams. On Gaskell Ward staff reported this as positive as meetings were staggered through the week. A member of staff talked of how they were "very proud" of their work and the working relationships they had with others and the "can do attitude" of staff.

Nursing shift handovers were documented. We found on Gaskell Ward that other professionals gave handovers regarding any risks or concerns for people they had worked with.

A pharmacist attended team meetings to give specialist advice to staff and people using the service. Staff spoke of the systems for supporting people to move on, such as the forensic community service and youth first.

### Mental Health Act (MHA)

We checked some people's care planning records and found evidence of people being provided with appropriate, timely information about their legal rights in relation to the detention under the Mental Health Act 1983.We found that detention papers were scanned onto the electronic patient record, including admission papers. We were advised that there were mental health administrators on site and there was a system to ensure that documents are scrutinised.

## The Tamarind Centre

### Assessment and delivery of care and treatment

The provider had systems for assessment and care planning as identified at Reaside. There were systems for updating monthly or if needs changed. Audits of care planning and assessment took place. Cedar staff told us about aiming to meet with people on a weekly basis to review people's care needs and care plans. Staff commented that sometimes it was effective to move

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people to a different environment to encourage them to get involved in care planning. Staff reported the need to check availability of staff resources/activities so as not to let people down and cancel activities.

Systems were in place to respond to people's physical health needs and we saw examples of comprehensive physical health assessments. Systems were in place for onsite medical emergencies.

People reported opportunities, subject to risk assessment, to learn or maintain their skills and independence to the level they felt they were able to manage. On Cedar Ward there was 'a room hygiene challenge' which people responded to and staff told us, "At a point we struggled to say who won because everyone got that good."

Occupational therapy activities were separated into four categories across the sites: life skills, leisure and creativity, health and wellbeing and education and work. SCALE groups such as anxiety management, social and conversational skill and, self-acceptance were available as people progressed.

### Outcomes for people using services

We found the use of outcome measures such as use of the SCALE model and My Shared Pathway (MSP) booklets and Health of the Nation Outcome Score (HoNOS) secure. A Quality Network peer and self-assessment had taken place at The Tamarind Centre but we noted the unit was less than two years old.

### Staff, equipment and facilities

Facilities at The Tamarind Centre included a gym and sports hall, library, hairdressers, a shop, multi-faith and chaplaincy service, GP and primary care suite, a dental suite occupational therapy area and visiting rooms. Staff reported access to interpreters and the use of phrase books on the ward. People on Hibiscus Ward reported having privacy when using the phone in their rooms. People reported having access to secure outside space.

Across the sites we visited, staff had identified that as part of modern life it was important the people could have access and use information technology, such as computers and games, in order to develop or maintain skills. However it was identified there were potential risks associated with this and there were risk assessments and protocols in place to minimise the risk to vulnerable people.

The service manager reported that the recruitment and selection for staff was developed over a three to four years process. They identified that there were some vacancies for band 5 nurse posts due to staff progressing with their career, and being promoted and some band 6 vacancies but it was a lower vacancy rate than the NHS average. Some healthcare assistants were undertaking nurse training. Block booking of bank staff was used were appropriate to cover staff vacancies and they could move flexibility according to ward need. The day we visited Hibiscus Ward, two out of five staff in the morning were bank or agency and four out of six in the afternoon. We looked at rotas for the last five months and saw that the majority of staff were permanent, but agency and bank were routinely used. Myrtle staff referred to staffing vacancies decreasing. Laurel Ward staff commented on using bank staff to cope with flexibility around seclusion and occasional use of agency. Managers told us the preference was to use regular bank staff, rather than agency.

### Multi-disciplinary working

Across all sites we found there were multi-disciplinary teams such as nurses, doctors, psychologists, occupational therapist (OT) and social workers.

We received some feedback from staff on Hibiscus and Acacia Wards that links with the OT and nursing staff could be more effective. Staff on Myrtle Ward referred to psychology team planning case presentations for staff learning and development. Staff reported opportunities for extended handovers for peer groups to share experiences and gain support if a member of staff was struggling with a case.

### Mental Health Act (MHA)

We checked some people's care planning records and found evidence of people being provided with appropriate, timely information about their legal rights in relation to the detention under the Mental Health Act 1983. We found that detention papers were scanned onto the electronic patient record, including admission papers. We were advised that there were mental health administrators on site and there was a system to ensure that documents were scrutinised. An example of this was a date missing on a detention paper and staff showed us that the mistake had been a rectifiable error and had been corrected.

Good

# Are services caring?

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

## Summary of findings

Most people told us that staff were approachable and gave them support, and staff demonstrated this. The provider had systems to encourage people to be involved in their assessment, care planning and reviews, through the use of recovery tools such as 'My Shared Pathway' and SCALE.

## Our findings

### Reaside

#### Kindness, dignity and respect

Most people gave us positive feedback regarding staff. They said that they could approach them with any issues they had and staff treated them with respect and care. Examples included a person who said Kennett Ward staff were, "Brilliant…they are all very individual and all bring something to the mix." Another told us "It's great here." On Avon Ward people's comments included, "Staff treat you with respect." They "help with recovery." "Staff are really good." On Severn Ward a person told us "There is empathy with the patients as far I can see." "Staff are very tolerant." People referred to friendly staff on Blythe Ward.

We found that people could access a telephone on each ward in communal areas. A previous Mental Health Act monitoring visit had identified a lack of privacy with these areas. We saw that the provider had made a request for privacy booths where needed.

People could have access to their own keys subject to risk assessment. On Kennet Ward we noted keys left in doors and some doors left open indicating a relaxed culture.

There were an observation policy for the service and bedroom doors had window vision panels that could be opened or locked. However a person demonstrated they could be opened indicating they were not fully private.

#### People using services involvement

We found several positive examples of engaging people in their care and treatment. However, we found that people were not always given appointment times for their clinical team meetings which led to them waiting around. Staff on Avon Ward reported either people chose not to attend activities or going to activities and then having to leave .Patients council meeting minutes evidenced that staff were encouraging more people to attend clinical team meetings and for people to give feedback on the service. We received mixed feedback regarding people's involvement in developing their care plans and meeting their keyworker. On Avon Ward there was evidence of newly admitted people signing care plans. We saw evidence in a person's care plan that they had been involved in planning around the use of restraint.

Most people reported having involvement, and some discussion, regarding their care and treatment. Not all people agreed with the team's feedback, for example relating to risk and the nature of their mental health issues.

We saw a difference between the daily ward based community meeting and patient council minutes. We saw that issues were raised but community meeting minutes such as Blythe Ward did not always detail what action had been taken to address them. Opportunities for people's involvement in developing their environment were seen. For example, the activities room mural on Severn Ward was planned and being painted by people.

On Kennet Ward a person gave feedback on the excessive amount of posters on the ward and struggled to see what information was of use to them. However they and others said they had influenced the board which detailed staff allocated to work with them that shift.

#### Emotional support for care and treatment

One person told us "I'm getting the help that I need…therapy tends to be a bit hit and miss."

Groups related to SCALE model groups to include core clinical and quality of life programmes, such as coping with emotions, mental health awareness and staying well after psychosis. We saw that there were opportunities for team or self-referral. Psychology staff told us there had been an investment in staff training to deliver therapies.

### Ardenleigh

#### Kindness, dignity and respect

On Gaskell Ward, we received mixed feedback about staff attitude to them. One comment was, "Staff here are brilliant" whereas some people reported that they did not feel staff listened to what they said and issues "were brushed under the carpet." Most people on Baker Ward and other wards told us staff gave them support and they felt listened to. A person told us they felt staff worked hard and were under a lot of pressure. Another person advised that staff were mindful of their physical health needs when

# Are services caring?

Good

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using restraint. During our visit to Armstrong Ward one young woman was using the service and the majority were young men/boys. There were gender specific areas to meet the woman's needs and maintain their dignity. We saw that other individual privacy and dignity issues had been addressed by the trust where appropriate.

There were identified areas throughout the service for people to have visits with family, friends or professionals in private. Additionally we saw care plans identified arrangements to support people to have contact as relevant via telephone and Skype (video link).

In the Gaskell Wards extra care area, a person was keeping their clothes in the bath. This was raised with staff who confirmed that additional storage facilities would be provided for them. In this area we saw there were limits to the possessions people could have due to risk, but we saw that people had some opportunities to personalise their room with a patterned duvet and photographs on the walls.

### People using services involvement

We saw a difference between the daily ward based community meeting and monthly held patient council minutes. We saw that issues were raised but community meeting minutes did not always detail what action had been taken to address them. From attending some of these meetings we saw that staff discussed and asked people about the activities they wanted for the day and to gain feedback. There was an agenda with headings 'How are you today', 'appreciations' 'positive thought for the day' 'service improvement '. We saw on some wards people chaired these meetings and took minutes. There was difference in the level of interaction, for example we saw that people in Gaskell HDU were less interactive in these meetings and therefore meetings less person centred.

The patient council meetings minutes, seen and dated February to April 2014, varied in quality and detail and differed across the women's service and CAMHS.

The CAMHS was a summary of issues raised in meetings provided by the 'see me' service user development service. There was more detailed information but not always actions and timescales. We saw that the April 2014 minutes identified that young people did not always feel they were involved in care planning. It was reported to the ward manager but unclear what actions were being taken and the timeframe for this. We saw that a person using this service was now attending the unit service delivery group. The CAMHS unit displayed 'a wall of change' which people had requested to evidence areas of changes they wanted and actions taken. Young people had been involved in choosing the decoration of communal games room.

We noted from a review of some people's care records, across wards, that it was not always clear how their views had been recorded within their clinical team meeting reviews. On Gaskell Ward staff told us that this was identified as an issue and they were looking at ways for people to compile their own report for the meeting.

### Emotional support for care and treatment

We received some positive feedback about advocacy services supporting people, for example on Gaskell Ward. We found that staff were offering support and guidance to young people going through puberty helping to manage the transition from child to adult.

We found assessments took place, or a specialist opinion was given, for people prior to admission to the service. In addition to activities and SCALE groups, a psychologist dialectical behavioural therapy was available if required. This was generally available as appropriate at the Thomas Telford centre women's psychotherapy as part of outpatient provision.

## The Tamarind Centre

### Kindness, dignity and respect

We received mostly positive feedback from people using the service. Examples included a person on Sycamore who spoke of how staff had helped them. On Acacia Ward several people told us they had good working relationships with staff and described them as caring and approachable. On Laurel Ward a person told us staff were, "Nice and friendly and treat us well". Another said "It's good here." They gave an example of how staff also managed to maintain their dignity when they were in seclusion and told us staff checked on them to ensure they were safe. Another told us, "My keyworker is really good and goes the extra mile."

A person on Myrtle Ward told us they had problems with getting clothing as they did not have contact with family and friends. We checked on this and found that each unit had systems in pace for supporting people to get toiletries and clothing, for example if they were not entitled to statutory benefits and had been admitted from prison. A

Good

# Are services caring?

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senior manager told us that it was important staff cared for people compassionately and professionally and it should be, “More than just a slogan.” Staff told us people were given a choice of staff gender where required.

### People using services involvement

A person on Myrtle Ward told us that people's voices weren’t heard unless they spoke with senior management. There were morning community meetings across all wards for people to raise any concerns and suggest ideas.

We attended a patient council meeting held monthly which was chaired by a person using the service. People had opportunities to learn about issues across wards, and the trust, and give their feedback on the service. For example an issue was raised for clarity about the number of items that could be brought in and if multi pack items were one item or not and a security team representative was to be asked to clarify. Also smoking times were discussed and a request was made to review this. Feedback was that this was being reviewed cross all sites. People had been encouraged to write articles for the unit ‘The Tamarind Gazette’ such as on the recent St George’s family and friends event, and contribute articles for ‘Trust Talk’ the provider’s quarterly magazine. We found that people were asked for feedback on the draft seclusion leaflet.

Staff on Myrtle Ward told us that they met with people before clinical team meetings (CTM) and they were given the option if they wanted to attend or not. There was a form completed to indicate people’s preferences for the meeting. Nursing staff attended the CTM first and made the request then for the person to come in for further discussion if they wanted.

On Laurel Ward a person said that complaints staff would help them with a complaint if they had any and that they were involved in discussions regarding their care, treatment and care planning.

### Emotional support for care and treatment

A person on Myrtle Ward told us they felt that staff had accused them of doing things that had not happened and staff records were sometimes inaccurate. That they did not know why they were in hospital. On Laurel Ward a person gave positive feedback that the services were better than where they had been before. They gave an example of attending a relaxation group and learning techniques to manage their anger.

# Are services responsive to people's needs?

Good

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

## Summary of findings

We saw evidence in people's care and treatment records of how the service had reviewed and amended treatments in order to meet their changing assessed needs. We reviewed some good examples of responsive and person-centred care during the inspection. There was an effective complaints management system in place. There was evidence of site developments to respond to people's needs.

## Our findings

### Reaside

#### Planning and delivering services

We saw from clinical governance meeting minutes that people's physical health and obesity were considered. For example people were encouraged to eat healthily when on leave and guidance was available regarding the food they brought back or family and visitors brought and this was discussed at the May 2014 patient council meeting. In the communal canteen there were healthy eating posters. For example, 'Healthy eating live well' promoted healthy foods and there was a traffic light rating for meals with fat/salt/sugar content.

For one person it was identified they had been on the Intensive Care Unit (ICU) for in excess of a year. Staff had requested an independent review of the person's care and treatment from another hospital to explore if other treatment options could be explored.

A person on Dove Ward told us that toilets could get blocked and take days to fix. We saw that there were systems in place for staff to report maintenance issues to the relevant estates department.

Information was available for staff, people and carers regarding access to interpreting services. We had some feedback from Blythe and Severn Ward staff regarding access to interpreting services, for people where English was not their first language. We checked and found that interpreting services were available but not provided at all times. Therefore situations had to be assessed and planned, such as for community team meetings.

#### Right care at the right time

A person on Severn Ward told us, "They're [staff] doing the best they can with what's available. They're doing a good service."

We received mixed feedback from people across wards regarding their access to activities. We saw that a range of activities and therapies were planned. We found at Reaside an audit had taken place to identify people's attendance and non-engagement in activities. Since November 2013 it identified there 'may be reduced quantity in hours', but an increase in quality and engagement with people was reported overall. There had been a larger emphasis on community integration in preparation for discharge.

#### Care Pathway

A person told us of how they had a bad experience of being admitted to hospital from the community. They told us that they were restrained, handcuffed and admitted via the police station. Consultants we spoke with told us there was a system in place for promptly assessing people in prison and other services however they were unclear about the waiting time for admission.

We found that there was a frequent decision-making forum, at clinical team meetings, in addition to care planning reviews to prevent unnecessary delays to discharge. We noted across sites that some people had spent a significant time in hospital. For example some people had spent years in services. It was difficult to give an estimated length of stay as treatment was individualised.

There was an identified care pathway for people who were admitted to the high dependency unit on Severn Ward to the acute wards and then to the rehabilitation wards. Some staff and people using the service highlighted that care pathways could include moving to high or low secure services such as Hillis Lodge, community accommodation or in some cases, return to prison. Staff told us that as part of the transition staff from other wards/services attended meetings before transfer/discharge.

Doctors and a social worker told us the forensic community service started working with a person whilst as an inpatient before they were discharged from hospital to the community to ensure continuity of care. Often people would have a conditional or supervised discharge. Staff told us that some people could be re-admitted to the unit if their mental health deteriorated to ensure continuity by their care team.

# Are services responsive to people's needs?

Good

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

We received mixed information across sites from people using the service about their care pathways. Those at the end of their stay in the service had a clearer sense of the care pathway than those who had been recently admitted. Staff told us that it took some time for people to respond to care and treatment and build up a working relationship with staff. One person on Avon Ward said they felt that people were kept in hospital longer than was needed. For one person on Dove it was identified that their discharge was delayed and that they were waiting for an appropriate placement to move to.

### Learning from concerns and complaints

Across the sites there was a variety of information available for people giving information about their rights, how to make a complaint, raise a safeguarding alert. We saw that the provider had systems for dealing with complaints. There were complaints/comments boxes on each ward which people could give anonymous feedback. A Patient Advice and Liaison Service (PALS) was available.

We received positive feedback in relation to Dove Ward, "She [staff] listens to what we say and tries to accommodate." On Severn Ward a person told us, "When you keep asking for things they do as you ask." Two people on Dove Ward referred to having made complaints and but not being happy with the outcome.

We found a sign on Avon Ward stating that if people were identified as smoking outside of smoking times that 'a unit search will be carried out during the next smoke break and this break will be forfeited.' A CQC Mental Health Act provider visit during 2013 for Blythe Ward had reported on a similar issue. The provider stated that notices had been reviewed and amended and smoke breaks would not be cancelled due to people smoking outside of breaks on the unit. We drew staff attention to this and staff offered to take the sign down.

## Ardenleigh

### Planning and delivering services

We noted the trust was the first Mental Health NHS trust to gain the globally recognised Autism Spectrum Disorder accreditation.

We received feedback from people across Gaskell, Baker and Armstrong wards regarding a lack of activities. A CAMHS OT identified that there had been a vacant post but this had been filled. Some people reported that activities did not always reflect their needs, for example they wanted more practical groups. We noted that the weekly activity schedule on Armstrong Ward had not been updated since 3 March 2014 and staff rectified this during our visit.

We saw that there were 'flexi groups' for people to make requests for activities they wanted that day. On Gaskell Ward a person raised their frustration not being able to attend the gym. Staff acknowledged that there had been some "confusion" about this. Staff reported there could be challenges due to the risks people may pose to getting them off the ward for physical activity but identified that exercise was important due to the medication they were on.

We found that people across Ardenleigh and Reaside had been encouraged with art projects and had submitted works to The Koestler Trust, a national charity with an awards programme for offenders, secure patients and detainees.

### Right care at the right time

Staff told us that Gaskell Ward now had a twilight shift as staff had identified that there was a need for people to have additional in the evenings. Staff explained 'flexi observations' were being trialled where the nurse in charge could review and agree with the person observation levels.

A psychologist explained the SCALE groups that took place in women's services such as risk reduction, arson, trauma and managing emotions. They stated that people's needs differed as they moved through the care pathway and across the HDU, Gaskell and Baker wards where more intensive work could be undertaken as people were more engaged.

### Care Pathway

A specialist Youth First service provided multi-disciplinary holistic assessments of young people to child and adolescent mental health services, youth offending teams, local authorities, crown prosecution services, solicitors and other agencies involved in youth justice regarding care and treatment.

We found that there was potential for a young person to transfer from the CAMHS unit to adult wards and there were systems for staff to meet with the person to manage the transition. We found on Gaskell Ward there was a 'leave

# Are services responsive to people's needs?

Good

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

bed' for flexibility for people who were discharged from the service to use if they were in crisis and needed a short hospital admission with care and treatment by staff and teams that knew them well.

The trust did not have low secure women's services. If a women's needs could not be met in the trust then out of area placements were explored. This had led to some people being placed a long way from their home area, such as in Sussex. They advised that regular bed management meetings took place to consider these issues. A proposal to develop the Ardenleigh site to provide this service had been made.

### Learning from concerns and complaints

We saw that patient council meetings took place however we noted that March 2014 minutes were the same as those for February 2014. Staff and people reported on actions however not all minutes indicated who was taking action and the timeframes. We saw in February that people had requested an Afro Caribbean hairdresser and it was 'a long standing item'. The issue was still being discussed in April 2014 and minutes did not indicate what the delay was. Equally staffing had been raised as an issue which was affecting activities such as leave. We noted a working party was set up to look at community leave trips and effectiveness. We saw that staff leave had impacted on staffing but were unclear what actions were being taken to address the issues.

We found that staff had been sent on customer service training after some feedback from people that this needed improving. A complaint was made by a person in CAMHS regarding staff not hand washing before meals and a complaint was being dealt with PALS support. During our visit a person on Gaskell Ward raised they had not received an outcome of their complaint. However the matron confirmed the actions that had been taken to address this. Other staff were able to refer to learning points from the outcome of this, such as the 'Our ward our home', initiative where people on another ward had developed rules for the ward about how they wanted to be treated. This was to be extended across other wards.

## The Tamarind Centre

### Planning and delivering services

We received some mixed feedback regarding the opportunities people had for developing their daily living skills. For example some staff and people on Hibiscus and Acacia raised with us that there was lack of activities and "rehabilitation" for people, that links with the OT and nursing staff could be more effective. More focus was felt to be on psychological therapies, with less opportunity for people to learn skills for daily life. We saw a detailed activities board but were told these did not always take place as, due to staffing issues, they could not always access the gym. Staff advised that this had been raised with managers but were unclear what action had been taken. On Lobelia some people were being supported to achieve 'level 2' food hygiene certificate. People across Hibiscus, Acacia and Myrtle ward told us they wanted more activities for paid employment. We noted that people had given feedback about this across other sites and links with Bourneville College and the planning of a Recovery College were a response to this. We saw some opportunities for therapeutic jobs at Ardenleigh but did not establish if this was available at The Tamarind Centre. A person told us that staff had been discussing opportunities to support them to learn skills for a future job.

People and staff told us that encouragement was given to attend activities included gym, cycling and badminton. Other examples given were people to access the community for day trips, the library and restaurant. We found a unit events committee was in place where people and staff could suggest and plan events. Positive feedback was given for the recent St George's day family and friends event.

### Right care at the right time

A person on Laurel Ward told us "I have achieved so much being here." Another said, "They are focused on rehabilitation."

Staff and people told us that they had opportunities to meet with their clinical team to review their care and treatment. Staff gave an example of a person requiring seclusion on a rehabilitation ward and arrangements were made for them to be moved to the Intensive Care Unit to ensure they got additional care to manage their risks.

### Care Pathway

There was an identified care pathway across the wards when admitted to the high dependency unit then moving to acute and rehabilitation wards. Some feedback from staff on Hibiscus Ward told us there was a delay between moving from acute to rehabilitation wards. Some staff reported that there should be additional 'step down' facilities to move people out of the medium secure unit before people were discharged to the community. We saw

# Are services responsive to people's needs?

Good

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

that the provider had systems in place to track bed occupancy and delayed discharges and held regular bed meetings with senior staff. We found examples where people had move to other sites to meet their needs. Some people we spoke with were unclear about what they needed to do to move on, for example if they were detained having come via the criminal justice system. The service manager told us that since The Tamarind Centre had opened 47 men, who had been placed in other hospitals elsewhere in the country, had returned to local services. This service meant that there was potential for people to move from high secure hospitals or prison, via the unit, to low secure sites or community placements. Alternatively people could have a crisis and then be re-admitted. Staff reported people being followed up by the forensic community team. These developments were positive for people.

**Learning from concerns and complaints**

We saw that the provider had a complaints system and could monitor trends across wards. Staff referred to local resolution of complaints via the PALs service, where possible, and that all complaints were 'signed off' by the CEO. Mostly people told us they felt able to raise any concerns with staff and have them investigated by the trust.

# Are services well-led?

Good

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

## Summary of findings

There was a range of ways that the provider gave information to staff and people about their service.

The provider had a governance framework in place; however, not all staff were able to explain this, for example relating to safeguarding systems.

Staff reported support from their line managers. They told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role.

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

## Our findings

### Reaside

#### Vision and strategy

We found that the provider's strategy was accessible on their website. Across all sites we saw posters referencing values and outcomes. Some staff spoke about ensuring "quality" within the service. However not all staff we spoke with knew about the strategy.

#### Responsible governance

We found examples of governance meeting minutes being discussed at ward team meetings such as Blythe. However, we found that not all staff were able to explain the governance structure and the differing meetings and how issues from their ward would be reviewed externally. An example of this related to safeguarding as not all staff knew about the role of the trust safeguarding lead and the systems for reviewing reported incidents.

Staff told us, across all sites, that they received mandatory training and there was a "traffic light system" of checking when they were in date. Staff told us that there was clear guidance on timescales for training, such as for restraint refresher training, and if not completed then staff had to undergo the full training to ensure they were competent. There was additional training as related to their role.

#### Leadership and culture

Staff reported having contact with their manager and next level of managers. Compared with the other sites staff reported less contact with board members. Staff referenced ways that they received information about the trust such as via emails, 'Trust Talk' magazines, and the 'Dear John' initiative where staff could anonymously give feedback to the Chief Executive Officer.

The matron told us that several new ward/unit managers were in post and an independent company was providing them with training and development for their roles. We received positive feedback from staff, across all sites, regarding the support they had from managers. Staff reported a buddy system where new staff were additionally allocated an experienced staff member to give them support. We received some staff feedback that staff moved wards, after a fixed period, which they had little choice over and could be unsettling.

#### Engagement

Staff across all sites referred to having team meetings and being able to raise issues with their manager or in other forums. Doctors we spoke with told us they felt there was a positive relationship between managers and the executive team.

The provider had a specific Service User Development team, known as 'See Me' across the sites. They had responsibilities for leading on and gaining feedback from people to influence and improve the service such as via telephone surveys, reference groups and attending community /patient council meetings. Information gained was reviewed and monitored via unit clinical governance meetings where further actions could be taken as required. We saw examples of this across the sites. The unit had 'Real Time Feedback', where service users are encouraged to complete questionnaires on tablet devices. Weekly reports are sent to clinical directors and operational managers. We saw that this was reviewed in the Residents Council Meeting. We noted that access to hairdressing was an issue raised across all sites. For example the minutes, dated November 2013, detailed a request for people to use hair clippers. This was raised and subsequent meeting minutes detailed that staff had responded by carrying out a risk assessment and drawing up guidelines to achieve this with plans to finalise them at the next meeting (six months later) in May 2014.

A listening into action event took place on Severn Ward in September 2013. Staff had highlighted areas where improvements were actioned such as gaining feedback from people about activities. Exit interviews take place at

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ward level when staff had left and a mentor system has been developed. There was more flexibility regarding bank staff booking to ensure they had the right staff with the right skills.

### Performance improvement

The trust is a member of the Quality Network for forensic mental health services and self and peer reviews of the service are routinely undertaken. The Quality Network reviews services against criteria which have been developed from the Best Practice Guidance: Specification for adult medium-secure services, Department of Health 2007 and we noted that their 2013 report had identified the provider had made positive changes and actions were being taken to address areas previously highlighted. For example changes in physical security, such as new windows, internal fences and new doors.

## Ardenleigh

### Vision and strategy

Some staff told us that the provider's strategy was discussed initially with new staff in their induction. Then later they received updates through team meetings, emails and newsletters.

### Responsible governance

Staff referred to multi-disciplinary attendance at local governance meetings. Staff told us that Monday meetings took place with the senior nurse team to review issues. We saw that there were systems across sites for governance meetings to review feedback from the trust and other site meetings.

### Leadership and culture

Some CAMHS staff reported strong links with senior managers who kept in contact and wanted to know what was going at ground level. Comments from staff regarding CAMHS mangers were "When [name] took over they listened to what staff were saying." Some staff told us that systems to report things to the executive team/board actions could take time however examples were not given.

Team meeting minutes we saw evidenced managers encouraging staff to give feedback on the service and the effectiveness of their management. Across all sites we received some feedback regarding changes to service development manager and lead nurse roles and uncertainty regarding line management accountabilities.

### Engagement

Staff fed back that they were sent surveys to complete and give feedback on the service. Additionally they reported opportunities to give feedback to their manager, via team meetings, via emails and via 'Dear John' to the CEO.

### Performance improvement

We had feedback from some staff in CAMHS that the new sickness policy had improved and this had reduced staff sickness levels. We received mixed feedback from staff regarding management and clinical supervision. Most staff reported having regular opportunities for individual and group supervision, clinical and management. Staff reported that they had responsibility to raise their supervision needs with their manager. Some staff reported not knowing how to access a clinical supervisor. Staff reported fortnightly group supervision with the psychology and fortnightly CLIP groups (Communication and Learning in Practice). We observed these were protected times. Staff across services referred to opportunities for multi-disciplinary reflective practice supervision where staff could discuss cases or challenges in their work. Staff gave examples of other specialist training available such as 'Prevent' training relating to CONTEST, the government's counter-terrorism strategy, which aims to stop people becoming terrorists or supporting terrorism.

## The Tamarind Centre

### Vision and strategy

Not all staff knew of the provider's vision or strategy but some had met the CEO and other executive team members.

### Responsible governance

Staff reported systems for learning from incidents and issues being discussed, for example at the security and risk management meeting. We were told there were monthly management meetings to support each other and share issues. We had some feedback that the traffic light systems for staff training took some time to get updated, after staff had undertaken training, and some staff had developed their own monitoring systems.

### Leadership and culture

We received some feedback from staff that their wards were well-led. A staff member reported that the CEO had developed systems for giving feedback to top managers, from the site and ward. Another referred to seeing executive team members and feeling that their influence

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was positive. Another staff member reported that sometimes it could be difficult to be innovative as systems can be restrictive. Other comments were that there was good support, staff development and flexible working.

### Engagement

Staff reported systems for giving feedback such as team meetings and supervision. A service manager told us, and we saw from a service user development team report, that people had given negative feedback on the food. Consequently people had met with a catering staff representative to improve the outcomes with the support of the See Me workers and staff with taster food sessions taking place, routine surveys conducted and the catering representative now attending the monthly patients committee. We received some mixed feedback that the range and variety of culturally appropriate foods and how good it was. On Acacia, Hibiscus and Laurel wards several people and staff reported food wastage due to managed food portions with no second helpings allowed and left over food thrown away. There were reports of food being too hot or cold and limited breakfast options. A deputy manager confirmed that people were not allowed second helpings but this was being reviewed. An opportunity for a cooked breakfast activity was requested at the patient's council meeting which staff planned to arrange. There were opportunities for people to have takeaways.

Some people told us of 'Come Dine with Me' at Tamarind Centre. We saw that the trust website referenced the idea was suggested by a person and that people took turns to devise menus and cook for staff and others under supervision, giving an opportunity for people to practice and develop skills that could be used once they were back in the community.

Some people at the patient's council raised smoking times as an issue. The service manager advised that this was being reviewed across the sites. Minutes we saw from patient council meetings did not always detail how actions had been reviewed and dealt with. For example, a request for full length mirrors was made in January 2014 then not allocated for action until February 2014. Minutes after then did not refer to the outcome. Also a lack of OT activities was identified in January and February 2014 with actions to be taken, yet March minutes did refer to the outcome.

### Performance improvement

We saw staff engagement plans for secure services for September 2013. A multi-professional team of staff met to draw together an induction programme for a new team of nursing staff prior to a new ward opening in Tamarind Centre. Staff referenced to receiving mandatory training. They gave other examples of training they had received for their role, such as diabetes training for healthcare assistants and training about gang culture. In addition to central induction there was a specific forensic induction across sites relating to working in a secure area. We had positive feedback, for example from Cedar Ward where some staff told us they felt valued, training facilities were good and they were encouraged to undertake training for their professional development. "They really push you here to do training which is really good."