

Coventry and Warwickshire Partnership NHS Trust

Hawkesbury Lodge

Quality Report

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Date of publication: 17/04/2014
Date of inspection visit: 21 and 24 January 2014

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

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Summary of findings

Overall summary

Hawkesbury Lodge is a 20-bedded, mixed-sex, secure rehabilitation unit in Longford, Coventry. Three of the beds are in a wing that is used as a 'step down' facility. It is one of four units providing rehabilitation and recovery services in Coventry and Warwickshire. Referrals are from community mental health or inpatient services. People are either informal or formally detained under the Mental Health Act 1983 (MHA) and have a severe and enduring mental disorder with additional physical, social and psychological needs, including substance misuse.

We found that staff had systems to keep people safe and for reporting any issues of concern. Risk assessment systems were available to keep people and the environment safe. People and staff were encouraged to give feedback on the service and this was used to measure quality and effectiveness. Staff reported feeling supported and having access to training. Some systems

for monitoring adherence with the Mental Health Act 1983 were in place. However, we did not find evidence that informal patients could access community leave as they wanted.

Staff used a 'recovery approach' to empower people to identify their own needs and the support required. People were given information and encouraged to give their views on their care; however systems for recording this needed improvement.

Staff at Hawkesbury Lodge had developed working relationships with other internal services, external community teams and agencies to help people access services. The rehabilitation and recovery service was developing systems to get greater feedback from people who used services and carers to influence the service.

Staff were given information and had an understanding of the governance framework, such as systems for feedback after incidents. Staff received support from their teams and line managers.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that there were procedures for staff and people using the service to report any incidents and for these to be investigated and reviewed to prevent them happening again. Staff undertook risk assessments for maintaining health and safety for people, staff and the environment. People were able to raise any concerns and have these looked into. There was sufficient staffing and skill mix for the unit. Staff managed people with challenging behaviour and prevented situations from escalating.

Are services effective?

There were systems in place, such as audits for measuring quality and effectiveness.

A multi-disciplinary team supported people at Hawkesbury Lodge and worked with other services in the provider and with external agencies. Staff reported difficulty in people accessing psychology services.

People and staff were encouraged to give feedback on the service and this was used to measure quality and effectiveness.

Four staff reported that, due to the increase in bed occupancy, more qualified nurses on shift were required for the service to be more effective.

Some paperwork on Hawkesbury Lodge relating to the implementation of the Mental Health Act 1983 and code of practice was not easily accessible when we visited. We identified that community leave plans had set conditions for people who were not detained.

Are services caring?

Staff reported using a recovery approach with people and involving them in their care planning and risk assessment. We found that care plans and risk assessments did not always record people's involvement and contribution to them. In addition to individual care reviews, recovery group focussed meetings took place, these gave people opportunities to be involved in activity planning and give feedback on the care they received.

People told us that most staff were supportive and helped them with their needs. We saw that people were being supported to move on from hospital.

There were gender-specific areas of the ward to ensure privacy and dignity.

Are services responsive to people's needs?

Hawkesbury Lodge had expanded its bed capacity so that people from out-of-area placements could return to be nearer their home community.

Staff at Hawkesbury Lodge worked with a range of external community teams and agencies to help people access services as part of their transition from hospital to the community.

Systems were in place for people to give feedback on the unit. The rehabilitation and recovery service was also developing systems to encourage people and carers to influence the service provided.

Summary of findings

Are services well-led?

We found staff had an understanding of the governance framework function, such as the mechanisms for reporting and learning from incidents to prevent them happening again. Staff could raise concerns at a local level, such as at team meetings and during supervision and by attending other meetings within the provider. Staff were aware of whistleblowing procedures to escalate concerns if needed and they knew who to report to. They told us they had regular contact with their immediate managers, but limited contact with executive team members.

Staff received information via email with updates on issues in the service. Staff referred to changes and consultation events taking place in the provider and reported concerns about the service's future. Some staff did not know how to give feedback centrally on provider issues.

We found that the multi-disciplinary team had systems in place to ensure people's detention under the Mental Health Act 1983 (MHA) was reviewed. Where appropriate, people could be treated as informal patients and not receive treatment under the MHA.

Summary of findings

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

Long stay/forensic/secure services

We found that staff had systems to keep people safe and for reporting any issues of concern. Risk assessment systems were available to keep people and the environment safe. People and staff were encouraged to give feedback on the service and this was used to measure quality and effectiveness. Staff reported feeling supported and having access to training. Some systems for monitoring adherence with the Mental Health Act 1983 were in place. However, we did not find evidence that informal patients could access community leave as they wanted.

Staff used a 'recovery approach' to empower people to identify their own needs and the support required. People were given information and encouraged to give their views on their care; however systems for recording this needed improvements.

Staff at Hawkesbury Lodge had developed working relationships with other provider services, external community teams and agencies to help people access services. The rehabilitation and the recovery service was developing systems to get greater feedback from people and carers to influence the service.

Staff were given information and had an understanding of the governance framework such as systems for feedback after incidents. Staff received support from their teams and line managers.

Summary of findings

What people who use the location say

We did not review any surveys that specifically related to Hawkesbury Lodge.

The rehabilitation and recovery service strategy and implementation plan review of October 2013 identified that service users and carers were not involved in the redesign of the rehabilitation service.

A project group was started across the rehabilitation and recovery service to gain views from carers and over 30 questionnaires were sent out and three were returned. It was identified that staff needed to work more on encouraging patients and carers to give feedback.

Areas for improvement

Action the provider COULD take to improve

We identified that community leave plans had set conditions for people who were not detained under the Mental Health Act. This indicated they could not access community leave when they wanted.

Hawkesbury Lodge

Detailed findings

Services we looked at:

Long stay/forensic/secure services

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan, OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included CQC inspectors, Mental Health Act commissioners and a variety of specialists which included a doctor, nurses and senior managers.

Background to Hawkesbury Lodge

The Trust has a total of 21 active locations serving mental health and learning disability needs, including three hospital sites: Brooklands, St Michael's Hospital and Caludon Centre. 11 of these locations provide mental health services including Hawkesbury Lodge in Coventry.

The Trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Coventry.

Coventry and Warwickshire Partnership NHS Trust has been inspected 21 times since registration. Out of these, there have been 12 inspections covering five locations which are registered for mental health conditions. Hawkesbury Lodge has not previously been inspected.

Hawkesbury Lodge is a 20-bedded, mixed-sex, secure rehabilitation unit in Longford, Coventry. Three of the beds are in a wing that is used as a 'step down' facility. It is one of four units providing rehabilitation and recovery services in Coventry and Warwickshire.

It features an airlock comprising of two locked doors set opposite to each other at the main entrance. Referrals are from community mental health or inpatient services. People are either informal or formally detained under the Mental Health Act 1983 (MHA) and have a severe and enduring mental disorder with additional physical, social and psychological needs, including substance misuse.

Our MHA Commissioners previously visited this service on 14 July 2012 and identified several issues for people formally detained under the Mental Health Act 1983.

Why we carried out this inspection

We inspected Coventry and Warwickshire Partnership NHS Trust during our wave 1 pilot inspection. The provider was selected as one of a range of providers to be inspected under CQC's revised inspection approach to mental health and community services.

Detailed findings

How we carried out this inspection

To get to the heart of people who use services' experiences 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?

The inspection team inspected the following core service at each inspection:

- Long stay/forensic/secure services

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about Hawkesbury Lodge. We carried out an announced visit on 21 and 24 January 2014. During our visits we held a focus group with nursing staff and observed a nursing staff shift handover. We talked with people who use services and staff from all areas of Hawkesbury Lodge. We observed how people were being cared for and reviewed care or treatment records of people who use services.

Long stay/forensic/secure services

Information about the service

Hawkesbury Lodge is a 20-bedded, mixed-sex, secure rehabilitation unit in Longford, Coventry. Three of the beds are in a wing that is used as a 'step down' facility. It is one of four units providing rehabilitation and recovery services in Coventry and Warwickshire.

It features an airlock comprising of two locked doors set opposite to each other at the main entrance. Referrals are from community mental health or inpatient services. People are either informal or formally detained under the Mental Health Act 1983 (MHA) and have a severe and enduring mental disorder with additional physical, social and psychological needs, including substance misuse.

Our MHA Commissioners previously visited this service on 14 July 2012 and identified several issues for people formally detained under the Mental Health Act 1983, such as:

People's involvement was not always evidenced in care plans and review documentation.

People were not clear of their right to access independent mental health advocates (IMHA).

Section 17 MHA 1983 leave conditions and risk assessments were not always clear, for example, stating, "To adhere to staff requests".

Capacity and consent to treatment was reviewed and recorded at three months, but improvements for recording within the first three months were required.

As a rehabilitation service, activities held did not have specialist input from activity workers or an Occupational Therapist.

Some MHA documentation could not be found.

Summary of findings

Staff had systems to keep people safe and for reporting any issues of concern. Risk assessment systems were available to keep people and the environment safe. There were systems in place for people and staff to give feedback on the service and as audits for measuring quality and effectiveness of systems. Staff reported feeling supported and having access to training. Some systems for monitoring adherence with the Mental Health Act 1983 were in place. However, systems did not evidence that informal patients were able to freely access community leave as they wanted.

Staff used a 'recovery approach' to empower people in identifying their needs and the support required. People were given information and encouraged to give their views on their care however systems for recording this needed improvements.

Staff at Hawkesbury Lodge had developed working relationships with other provider services, external community teams and agencies to help move people across services as required. Systems were in place

for people to give feedback on the unit and the rehabilitation and the recovery service was developing systems to get greater feedback from people and carers to influence the service.

Staff were given information and had an understanding of the governance framework such as systems for feedback after incidents. Staff received support from their teams and line managers and there were systems for giving feedback on the service.

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Learning from incidents

The ward manager told us that there had not been any serious untoward incidents (SUI) on the ward for the last year. There were incident reporting procedures in place. We reviewed electronic incident logs and found that there were procedures for staff and people using the service to report any incidents and for these to be reported to relevant agencies, investigated and reviewed to prevent a reoccurrence. For example where a person was identified as at high risk of absconding from the unit and needed greater security, then a referral would be made for secure care.

Staff told us they gained feedback on incidents they had reported and any areas for improvement. An example was given where the matron contacted staff after an incident where a person was reported as absent without leave (AWOL) and the AWOL policy had not been followed. We saw records that showed us nursing and medical staff had carried out a risk assessment, but not fully documented this in the notes or incident form.

Safeguarding People

Three people told us they felt safe on the ward. Staff we spoke with had training to safeguard vulnerable adults including training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Most staff were aware of the need to report abuse. An identified safeguarding lead was contactable for advice and information within the provider. During our first visit a person raised a possible safeguarding issue with us and a staff member seemed unclear that it should be reported via the safeguarding or complaints process. We checked after our visit and found a safeguarding alert had been raised and was being investigated.

People could have access to most items as part of their daily living such as cigarette lighters, mobile phones and computers subject to risk assessment. There were outside smoking areas but we noted from incident reporting that occasionally people were smoking inside. Staff told us there was a management plan to reduce the incidence of smoking inside the ward and they monitored people to ensure the risk of fire hazard was minimised; people's risk

assessments reflected any change needed in their care plan. In order to minimise the risk of people using illicit substances, systems were in place such as random drug tests for people and room searches.

In the event of a physical health emergency staff told us they would dial '999' for emergency services. Staff reported having basic life support training to deal with emergencies and training records indicated 90% staff completion of this.

Several people told us they felt the unit was very clean and senior staff checked that cleaning took place. Audits took place to ensure health and safety standards within the unit. These included checks on infection control measures, such as the monitoring of food safety and staff use of personal protective equipment such as gloves and aprons. There were systems in place for the Control of Substances Hazardous to Health (COSHH). Staff had systems for checking the management of medicines were safe.

A ligature audit had been undertaken in July 2013 and areas identified as potential areas of risk, such as window handles, were recorded as 'managed'. The provider's assessment of ligature points policy 2012 referenced all audits had a checking system carried out by senior managers and the Clinical Audit and Effectiveness Department to ensure risks were safely managed.

Some of the screws on anti-barricade doors had been painted over which prevented staff gaining access to people in the event of an emergency. We saw maintenance staff visited the ward to discuss resolving this issue. We noted that the implementation of anti-barricade doors was one of the top five risks identified in October 2013 on the provider risk register for secondary care mental health services (SCMHS) and the provider had a maintenance plan identifying priority areas for having these doors fitted.

Risk Management

Systems were in place for assessing people's needs on admission, developing care plans and risk assessments and reviewing these. We saw that risk assessments included use of Health of the Nation Outcome Scale (HoNOS) risk assessment tool. Staff told us there was not a specific risk assessment document that was used before people went on leave.

Assessments considered the risk of any physical health issues. People had weekly physical observation checks and staff used the Modified Early Warning Score (MEWS) scoring system. More detailed physical health checks took place six

Long stay/forensic/secure services

monthly with people's consent. Lifestyle risk documents were completed relating to smoking, exercise and substance misuse. People with diabetes had management plans and regular blood glucose tests. We did not find that people's weight or body mass index was recorded. We found side effects of medication on physical health had been considered for three out of five people, through use of the high dose anti-psychotic monitoring sheet (HDAT) checklist of risk factors.

Safe Staffing

The unit is staffed on a 24 hour basis by nurses and Support Time and Recovery (STR) workers. The provider's rehabilitation and recovery service strategy and implementation plan review of October 2013 showed that a staffing skill mix review had taken place. As a result of this, an occupational therapist was added to the multi-disciplinary team in addition to doctors. Staff told us that they had started a pilot to ensure that support workers were available for a "middle" shift in the day to further support activities which had gained positive feedback from people and staff.

We saw from nursing rotas that there were systems to ensure adequate staffing and flexibility to ensure people's needs were met. Staff could request additional staffing resources as required. The ward manager told us that they did not have direct access to a psychologist and that this had first been requested five years ago. The rehabilitation and recovery service strategy identified that Coventry units such as Hawkesbury Lodge had no access to psychology services; psychology leads had identified that this would not be possible within current resources.

Four staff reported adequate staffing, although since increasing the number of beds from 14 to 20 they needed more qualified nurses on duty. Staff told us that they did not use agency staff and where required they used regular bank staff (these are staff that are not permanent but are employed by the provider) to ensure consistency of approach.

Are long stay/forensic/secure services effective?

(for example, treatment is effective)

Guidance and standards

Staff actively worked with people using a 'Recovery' approach in the service. 'Recovery' is a word commonly used by people with mental health problems to describe their struggles to live meaningful and satisfying lives. The principles of 'Recovery' are used in other mental health services in England and other countries such as the USA. 'The rehabilitation and recovery service strategy and implementation plan review, October 2013' detailed a recovery approach as underpinning staff's work with people. The strategy referenced its service in line with national Department of Health, 2011, Mental Health Strategy 'No Health without Mental Health', and the provider's strategic objectives.

The provider is a member of Implementing Recovery for Organisational Change (ImROC). Through a framework of 10 key challenges, the ImROC programme works with mental health services and their partners to focus their services around the principles of recovery and to help more people recover.

Staff used the mental health recovery star assessment linked with recovery plans in people's care planning files. The recovery star is often used as a key-working tool where staff support people they work with to understand their recovery and evaluate their progress.

Multi-disciplinary working

In addition to the multi-disciplinary team involved in the person's care in the unit, people had an identified community care coordinator involved in care reviews. Staff reported contacting teams to ensure people had an identified contact and to invite them to reviews. They reported good links with external community teams, such as the Early Intervention Team and ACT on service. Staff told us the average length of stay for people had reduced from three years to nine months. Where possible, people were helped to move on from hospital to a community based setting to independent residential or group homes, supported living or their own home.

Systems were in place to request an Approved Mental Health Practitioner (AMHP) to coordinate assessments

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under the Mental Health Act 1983. If people's mental health deteriorated then they would be admitted to an acute admission ward if needed. People were encouraged to register with a GP and to access any community based health services. There were arrangements in place for people to receive blood tests, electrocardiogram (ECG) tests, when required, at the Caludon Centre.

The rehabilitation and recovery service strategy identified a mapping exercise was taking place to identify resources including social care and third sector agencies, across Coventry and Warwickshire to improve the care pathway and identify other potential working relationships to help people move on from hospital.

Measuring quality

On admission people had a four week assessment period to see if they felt comfortable in the unit and for staff to consider if their needs could be met there or if an alternative placement was required. If after that time the assessment showed it was not suitable, alternative services would be identified.

Systems were in place for people using the service, staff and others to give feedback on the quality of care, such as reviews, suggestions boxes, NHS and provider surveys. These were reviewed and actions taken for issues identified.

We saw there were a range of audit and governance systems at ward level and provider level to monitor and review the service provided. In addition to audits measuring the safety of Hawkesbury Lodge there were other systems for auditing samples of care plans/people's notes. We noted actions were identified regarding improving the quality of information about people prior to and on admission. Information was displayed for people and others on areas of performance and improvement.

From our observation at staff handover we noted staff reviewed the support given to people that day. Staff referenced people's physical and mental health issues including if they were "settled" and if they had eaten well. They considered daily living skills and abilities. However, we did not see that issues discussed were directly related to people's care and recovery plan.

The rehabilitation and recovery service strategy identified developing a process of evaluation, which would provide

evidence of progress against the specific targets set out in the strategy. As part of this they planned to develop a set of measurable benchmarks and a six monthly process for evaluating against the benchmarks with peer evaluation.

We identified that community leave plans had set conditions for people who were not detained under the Mental Health Act. This meant they could not freely access community leave as they may want. Inpatient rehabilitation services used a standard document specifying conditions of leave for all people. People had signed these plans indicating their agreement and that they had been consulted. Conditions specified the frequency, duration, need for escorts and where they could go. Several records identified the person's mental health must be 'settled' before they could have leave, but there were no descriptors for this. One form identified 'leave at nursing discretion'.

Staff advised that people could leave the ward at any time and would only be prevented if they were detained under the Mental Health Act and their mental health needs and risk assessment indicated otherwise. Both airlock doors were locked. We asked a senior manager for evidence that people's leave was not being restricted, such as an audit on leave taken by people. We were advised leave records were kept in people's daily notes and there was no audit of how often people not detained were able to leave Hawkesbury Lodge.

Supporting Workers

Systems were in place for new or bank/ agency staff to receive inductions to the ward and provider. Specific staff had responsibilities to ensure staff had refresher annual mandatory training and protected time to undertake training as relevant to their role such as risk assessment and care planning. Staff had basic life support skills and management and prevention of physical aggression (MAPA) training for de-escalation and safe breakaway techniques.

Staff we spoke with reported feeling supported in their work and all staff said their manager/supervisor was accessible for advice and guidance as required.

Training records seen did not show all staff had completed mandatory training. For example, only eight out of 30 staff had completed fire training. The manager told us there was an error on their system and staff had completed their one day mandatory training. The October 2013 provider

Long stay/forensic/secure services

integrated performance, safety, quality and service user experience report 2013/14 reported that mandatory training for the provider was on track at 56.62% against the year to date target of 56%.

A system was being developed to ensure 'recovery' orientated supervision, appraisal and competencies was based on the 'Ten Top Tips for Recovery Orientated Practice' (Centre for Mental Health). Staff told us they had little recent specialist recovery training. Staff told us they had opportunities for individual and group supervision, including monthly team meetings.

Adherence with the Mental Health Act Code of Practice

Systems were in place to request a second opinion appointed doctor (SOAD) for people assessed as lacking capacity to make decisions regarding their treatment. People could request appeal hearings with hospital managers and first tier tribunals to review their detention under MHA1983. During our visit a person attended a Tribunal and was discharged from detention under MHA 1983. Staff spoke positively about the outcome and the discharge care planning arrangements made to move the person from hospital into the community.

We reviewed records of four people detained under MHA 1983. We considered how the Mental Health Act and Code of Practice was being adhered to. One person's S17 leave documentation did not specify the number of staff escorts and their designation.

We found a discrepancy in the records for one person, relating to documentation 'T2' dated 8 January 2014 indicating that they had been assessed and found to have capacity to consent to their treatment. However the date recorded for their assessment of capacity took place nearly one week later on 15 January 2014. This indicated the assessment was not carried out with the person on 8 January 2014.

We found evidence of people routinely being informed of their rights to appeal against detention under Section 132 MHA 1983. However evidence that they had been advised of their right to meet with an independent mental health advocacy (IMHA) was lacking. The manager referred to information available to people regarding general and independent mental capacity advocates (IMCA), but was

unclear if there was an IMHA service to support people who were detained. We checked on this and the provider had arrangements with a service to provide general advocacy and IMHA. Visits were dependent on people/staff's request.

Are long stay/forensic/secure services caring?

Choice and involvement

The rehabilitation and recovery strategy October 2013 stated 100% of people across services had completed the mental health recovery star assessment and recovery plans. It identified that people were encouraged to write in their health records and share decision making. Some people told us they were involved in care planning and reviews and others were not. We found evidence of the recovery star tool completion relating to issues identified in people's care plans/recovery plan. Care plans were developed using the care programme approach (CPA) and people had named nurses and where relevant, community care coordinators. Some care planning and risk assessment documents were not signed or people's views recorded; it was unclear if the person was consulted or not or had a copy. Some mental health care plans were generic for several people and not individualised. Senior staff told us they would ensure staff recorded and reflected people's involvement more.

There were opportunities for people 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, cooking, money management and travel by public transport. Where people could manage, they were given a weekly allowance to buy food. If people were unable to do any activities of daily living (ADL), staff supported them. Systems were in place to assess and encourage people to take responsibility, for example in taking their medication and monitor their blood glucose levels. This was not consistently documented in the care plans and risk assessments we saw.

Weekday morning meetings took place with people and staff and we received some positive feedback about their value. The focus was for people to raise and discuss any issues and plan activities. During our visit two people were going with staff to the National Space Station using the unit's minibus.

Long stay/forensic/secure services

Developing trusting relationships

Multi disciplinary team reviews of people's treatment and care were referred to as recovery meetings and these were held on the ward. People could request their community care coordinators and relatives to attend these or CPA reviews. Additionally, people could meet with nursing and medical staff as required.

Most people reported knowing who their named nurse was and that staff treated them with respect. They told us they could approach staff with issues they had. However, most people said other residents on the ward were less respectful to them. They told us they had opportunities to give feedback on this, such as in community meetings, but there was little change.

Getting the right support

One person told us how they had wished staff had given them more verbal explanation of the medication they were taking and side effects, instead of just having written information. Another said they felt frustrated at the length of time it was taking to find a placement to move onto and felt staff on the ward and community could do more.

Staff reported people had a low level of physically aggressive incidents. Staff told us they managed situations with de-escalation techniques and engaged people to move into a low stimulus environment to manage and prevent escalating situations.

People we spoke with gave positive feedback on the service provided. They said staff gave them the support they needed. One person said they felt staff could support them more with monitoring their blood glucose levels and diet to manage their diabetes. Some people talked of how they had moved to the unit from more secure hospitals and now had more opportunity for independence.

People told us they had opportunities for leave and for smoking. Some people told us that the kitchen was not always open when they wanted it and that they did not always like eating the 'cook and chill' food. We received mixed feedback regarding access to a computer and technology on the ward. One person said it was useful to look up things such as accommodation, whereas another said it was not now available as the computer needed replacing.

Privacy and dignity

There were gender specific areas of the ward to ensure people's privacy although some people reported men and

women using any toilets available. A women's bathroom was in a male corridor but rarely used and if required staff would ensure the area was private and safe. At the time of our visit, the step down area was male only as there was not the option of creating separate male and female areas; one woman was identified as 'step-down' and had a bedroom in the women's area. One person reported that they were unsure why staff had to open their door to check on them at night as they were informal. We were told that this was standard practice as part of staff carrying out routine observations to ensure people were safe.

A Patient Environment Action Team (PEAT) self-assessment of the unit was undertaken in 2012 and no risk issues identified. PEAT (now replaced by patient-led assessments of the care environment, PLACE) is undertaken by teams of NHS and private/independent health care providers and 50% members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration and the extent to which the provision of care with privacy and dignity is supported.

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

Meeting individual needs

The rehabilitation and recovery strategy October 2013 identified that a review of the patient pathway had recently taken place. Approximately 320 patients were identified in out of area provision and approximately 40 of those were in a secure mental health service. Arrangements were being made where possible to 'repatriate' people, bringing them back to services locally. Staff told us how Hawkesbury Lodge now had more beds to bring people back from out of area. A low secure service had been in the planning but was not now being developed but staff did not know the reasons why. They advised that people requiring longer term secure adult mental health services were still placed out of area. The provider's Quality Account 2012/2013 identified that 50 people had been brought back to placements such as Hawkesbury Lodge to receive care and treatment.

Transition to other services

A 'Single Point of Entry' multi-professional meeting was implemented in June 2013 across all rehabilitation and

Long stay/forensic/secure services

recovery services. Its focus included reviewing the rehabilitation service's waiting lists and bed occupancy, considering transfers between units and identifying any delayed discharges. The aim being to offer a responsive and effective service to people and not cause delays to their care pathway.

If people's mental health deteriorated at Hawkesbury Lodge, and the person needed a more specialist service, then staff would liaise with other services such as the Psychiatric Intensive Care Unit (PICU) at the Caludon Centre in Coventry. One person told us they were keen to be discharged and they had contact with their community care coordinator and placements were being explored. Staff told us that people might move on to another supported unit or to their homes and that sometimes it could be difficult to find the appropriate placement for the person. We found staff liaised with community teams regarding discharge packages and NHS and Local Authorities regarding funding.

Additional to the mapping exercise taking place, information on the intranet for staff was being developed, including what placements and accommodation was available to people from the private and voluntary sector. This helped give people and staff information about community services and accommodation when considering a person's care pathway and move on from hospital.

Learning from concerns and complaints

People we spoke with gave positive feedback on the service provided and said staff gave them the support they needed. Weekday morning meetings took place with people and staff and we received some positive feedback about their value.

Systems were in place for people using the service, staff and others to give feedback on the quality of care, such as reviews, suggestions boxes, NHS and provider service user satisfaction surveys and discharge surveys. These were reviewed and actions taken on the identified issues. Additionally, the provider website gave access to independent sites for people to give feedback such as 'Patient Opinion' and 'NHS choices'. When issues were raised by people across the service, feedback was shown via notice boards in a 'You said.... we did...' style.

The rehabilitation and recovery strategy October 2013 identified areas of improvement for involving people and

carers in the service. This included initiatives for the development of 'Peer Experts', people using the service to act as consultants, and encouraging applicants with 'lived experience of mental ill health' to apply for staffing posts.

A project group was started across the rehabilitation and recovery service to gain views from carers and over 30 questionnaires were sent out and three were returned. The responses identified that staff needed to work more on engaging carer's feedback.

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

Governance

Staff told us they understood the provider's governance framework function, such as the mechanism for reporting and learning from incidents to prevent reoccurrence. Staff referred to their involvement with groups and forums relating to governance. They had access to corporate services for development and learning, such as mandatory training and access to human resources and occupational health support. Staff talked of getting feedback on issues via staff team meetings. Several staff talked of changes taking place within the organisation and were aware of staff consultation events. Staff reported that other leads within the provider, such as safeguarding, were available for advice and expertise.

Staff told us that there had been changes across the service and were awaiting information relating to this. The providers website and Service directory 2014 information also gave differing information regarding the rehabilitation service and referred to Hawkesbury Lodge as a residential unit whereas it was clearly a 'locked' service.

Staff feedback systems

There were systems for staff to raise any concerns at a local level such as via team meetings, supervision, appraisal and by attending other provider meetings. Staff were aware of the whistleblowing procedures to escalate concerns if needed. We learnt that a member of staff who had an accident on an oven had reported the incident and a replacement was made. The member of staff reported feeling supported after the incident.

Leadership

We found systems were in place to manage staff. Supervision and appraisals took place to review staff ability

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to carry out their role. Managers spoke of the support and guidance they got from their immediate line manager. We found there were opportunities for staff to undertake training, such as leadership, and supervision to support them in their roles.

Staff engagement

We found that staff had information about the provider vision and we saw this displayed in the unit. Staff understood the aims for their service and there were systems for giving feedback. Staff reported clear lines of

accountability and knew who to report to. They told us they had regular contact with their immediate managers, however reported they had limited contact with executive team members.

Governance Framework for Mental Health Act duties

We found that the multi-disciplinary team had systems in place to ensure people's detention under the Mental Health Act 1983 was reviewed. A senior manager advised that the mental health act administration office was based at the Caludon Centre and had responsibilities for monitoring and auditing processes relating to MHA 1983, in addition to the ward managers.