



Northamptonshire Healthcare NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RP1V4	Berrywood Hospital	Meadowbank	NN5 6UD

This report describes our judgement of the quality of care provided within this core service by Northamptonshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Northamptonshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire Healthcare NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are 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

We rated Long stay/rehabilitation on mental health wards for working age adults as good because:

- Patients had a positive experience of care and told us they felt safe on the unit. Patients attended community meetings daily, raised issues, and gave feedback to staff both at the meeting and through the trusts' own feedback system called 'I want great care'. Staff ensured that patients and their carers knew how to make a complaint and patients had access to advocacy services.
- Staff treated patients and their families with care, compassion and respect.
- The multi-disciplinary team worked well together and focused on patient recovery. Most staff described the electronic system to report incidents, how learning was shared and knew their role in the reporting process.
- Staff undertook comprehensive assessments and reflected patients' needs and goals. They completed individualised risk assessments at or before admission and updated them regularly according to need.

- All staff were trained in and had a good understanding of the MHA and MCA.
- Staff told us they felt supported to carry out their role and had regular appraisals. Some staff had undertaken specialist training relevant to the patients' needs.

However:

- Medical staff told us that the trust had made decisions without adequate consultation, particularly over the changes to bed numbers on Meadowbank. Medical staff told us that medical staffing was under-resourced.
- Staff were unclear about whether a patient for whom a DoLS application had been made should be considered as detained or as informal.
- One patient told us that one member of staff was unhelpful, negative and did not engage in meaningful conversation with them.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

- The wards had a ligature risk assessment and staff knew where the risks were and how to manage them. The ward was equipped with a number of anti-ligature fittings.
- The wards were clean and well maintained and staff adhered to good hygiene and infection controls.
- Staff completed risk assessments on or before admission and updated them regularly. Patients' goals and positive risk taking were considered.
- Most staff knew how to report incidents and learning was shared.
- The ward was secure with systems in place to manage safety.
- Staffing levels on the ward were appropriate and there was a good staff skill mix on the ward including specialist workers.
- All staff had completed safeguarding training and the service made appropriate referrals to the local authority. Mandatory training was high and met the trust's target.

However:

- One staff member was not aware of how to report incidents.

Good



Are services effective?

We rated effective as **good** because:

- Staff completed comprehensive assessments in a timely manner and there was evidence of regular physical health checks.
- Staff followed guidance when prescribing medicines and psychological therapies were available with no waiting list.
- Staff were experienced and skilled and felt supported in their role. Ninety three per cent of staff had received an appraisal in the last 12 months, which met the trust's target.
- All staff were trained in and had a good understanding of the MHA and MCA. Staff assumed patients to have capacity and were supported to make decisions. Case records reflected staff's knowledge of the MHA and MCA and they knew where to go for further advice if needed.
- Patients had access to independent mental health advocates.

However:

Good



Summary of findings

- Although staff received regular supervisory support at team meetings and reflective practice meetings, trust data indicated that the service did not meet the trust's target for individual staff supervision.
- Medical staff felt service provision could be improved by accessing specialist training in personality disorder.
- The service was unclear about how to treat someone they had referred for a Deprivation of Liberty Safeguards (DoLS) authorisation.

Are services caring?

We rated caring as **good** because:

- Patients were involved with care planning, which was focussed on moving them onto more independent settings and included them setting goals for themselves.
- Staff we spoke with showed understanding of patients individual goals and needs.
- Patients told us most staff were respectful, kind and caring.

However:

- Patients told us staff spent too long in the nursing office and some staff were unfriendly and unhelpful.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

- Patients actively participated in daily community meetings and raised issues using 'I want great care' which staff responded to promptly.
- Staff focused their attention on patients' recovery and worked with other professionals to find suitable placements for patients. Staff had considered ways to reduce bottlenecks by devising daytime rehabilitation programmes for patients on the low-secure ward.
- Patients could access a number of activities both inside and outside the unit with support from staff.
- Patients could make private calls in one of the quiet rooms or in their own bedrooms.
- Staff compliance with diversity and human rights training was 100%. The unit provided information about different faiths and it catered for people with religious food requirements when asked.

Good



Are services well-led?

We rated well-led as **good** because:

Good



Summary of findings

- The manager collected and used data about staff performance to assess how well the team was working and where they could make improvements.
- Staff told us morale was positive, they felt valued and managers were supportive.
- Staff knew and agreed with the trust's values and wanted to provide high quality, person-centred services and to make a difference.
- Staff were able to submit items to the trust's risk register and knew how to whistle blow.
- Shift records showed there were sufficient staff on duty with a good mix of skills and experience.

However:

- Medical staff told us that the trust had made decisions without adequate consultation, particularly over the changes to bed numbers on Meadowbank. Medical staff told us that medical staffing was under-resourced.

Summary of findings

Information about the service

Meadowbank is a male rehabilitation ward and provides services for those who have been identified with a need for further rehabilitation, including as a step down ward from Wheatfield low-secure unit, both of which are sited at Berrywood Hospital, Northampton.

Meadowbank is a locked ward but patients have a key fob so they can access the building independently. The service aims to help individuals re-build their lives in a safe and caring environment.

Meadowbank is an eight bedded ward and provides rehabilitation for those patients who require assistance in the recovery process from a particular mental health problem. Patients admitted to Meadowbank may have come from Wheatfield low-secure Unit. The recovery process involves rebuilding existing skills or learning new skills in everyday living to increase independence and to ensure any future admissions back to hospital are kept to a minimum. It is a purpose-built facility with up-to-date amenities to encourage rehabilitation including a gym, sports area, library, multi-media room, arts studio, cafe and rooms for therapy sessions.

Meadowbank will take patients from all areas of the county of Northamptonshire; it operates a 24 hour, seven days a week service, fully staffed by qualified and healthcare assistant nursing staff. The teams who worked in this service also worked across Wheatfield Unit as a combined team.

Referrals come from a variety of sources that include the low-secure unit, adult mental health treatment wards, out of area placements, private sector providers of rehabilitation services both open and locked facilities. The age range is 18 years plus and access criteria is through the bed management process which is organised by the Forensic and Rehabilitation In-Patient Service.

This service was last inspected as a joint core service with Wheatfield low-secure unit in February 2015 and was rated as requires improvement overall. The caring domain was rated as good. CQC identified the following areas of improvement:

- The trust must ensure that the unit complies with the guidance on same sex accommodation.

- The trust must ensure that there is a clinic and physical examination room that is fit for purpose and resuscitation equipment that is checked regularly for use in emergency case.
- The trust must ensure that all risk assessments are followed. There was risk identified that patients were smoking in their bedrooms.
- The trust must ensure that all incidents and safeguarding concerns are reported.
- The trust must ensure that care records are detailed enough and contain all relevant information about care provided.
- The trust must ensure that clinical audits are carried out regularly to monitor quality and the effectiveness of the service.
- The trust must start work on training all staff and develop systems to monitor and manage the effective use of the Mental Capacity Act and Deprivation of Liberty Safeguards. This is important to ensure that staff can use the legislation with confidence to protect people's human rights. Assessments of patients' capacity to consent under MHA are detailed enough and available for all patients.
- The trust must ensure that all patients on high doses of clozapine were checked regularly for clozapine levels in their blood. It must also ensure that abnormal blood results were followed with further investigations.
- The trust must ensure that patients' privacy and dignity is protected at all times.
- The trust must ensure that the governance processes in place to manage quality and safety monitors all areas of quality and safety within the units to ensure that improvements are made.
- The trust should ensure that there is a detailed risk management plan or action plan to adequately manage the risk of potential ligature in the disabled communal bathroom.
- The trust should ensure that there is a clear policy on referral and acceptance criteria on patients admitted to rehabilitation service and that it is followed.

Summary of findings

- The trust should ensure that there are rooms where patients could relax or sit privately and quietly, consider enough space for therapeutic activities and that there is a designated room where patients could meet visitors in private.
- Although patients told us that they knew how to raise complaints when they wanted to, the trust should ensure that they were listened to and feel confident to complain and that staff would act to resolve the issues.
- The trust should ensure that the team's and the organisation's values are embedded in practice and that senior managers regularly visit the unit.

- The trust should ensure that the unit has strong clinical leadership that has got a good understanding of the unit's dynamics.
- The trust should consider that the senior management involves and consults staff with changes that happen within the unit.
- The trust should consider participating in a national quality improvement programme such as AIMS.

These were reviewed as part of the inspection. The trust had addressed identified concerns and implemented measures to prevent reoccurrence.

Our inspection team

Our inspection team was led by:

Chair: Mark Hindle, Chief Operating Officer, Merseycare NHS Foundation Trust

Head of Inspection: Julie Meikle, Head of Hospital Inspection, Mental Health, Central East, CQC

Lead Inspection Manager: Tracy Newton, Inspection Manager, Mental Health, Central East, CQC

The inspection team consisted of a CQC inspector, and a variety of specialist advisors which included Mental

Health Act reviewers and pharmacy inspectors. We were also supported by specialist advisors including two nurses and an expert by experience. An expert by experience is someone who has either used a service or has cared for someone using a service.

The team would like to thank all those who met and spoke with the team during the inspection and were open and balanced in sharing their experiences and perceptions of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited Meadowbank at Berrywood Hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients and one carer of a patient who was using the service

Summary of findings

- attended and observed a therapeutic group for patients
- spoke with the ward manager and ten other staff members; including doctors, nurses, psychologists, occupational therapists, healthcare assistants and sports therapist
- spoke with one student nurse and one volunteer
- received feedback from patients at three focus groups
- observed an informal staff discussion.
- looked at four treatment records of patients
- carried out a specific check of the medication management on the unit
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- We spoke to six patients who shared both positive and negative comments about their experience of living on the ward.
- Patients were positive about the way staff supported them. Patients liked having their own room key and that they could do their own shopping and cooking. Patients told us they enjoyed having the freedom to have things in their room such as stereos and mobile phones.
- Patients commented positively about the support they received from staff in relation to personal hygiene, cooking and employment advice and assistance.
- Some patients said that a few staff were not very helpful and that they had little communication with them.

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should ensure staff know how to treat someone they had referred for a Deprivation of Liberty Safeguards (DoLS) authorisation whilst awaiting a decision from the local authority.

Northamptonshire Healthcare NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Meadowbank ward	Berrywood Hospital

Mental Health Act responsibilities

- All staff had completed training on the Mental Health Act (MHA) and Code of Practice. Staff told us the training was relevant to their job role and they knew where to go if they needed further help.
- Case records and medication charts showed staff completed consent to treatment forms (T2) to record a patient has agreed to the treatment prescribed. T3 forms were completed by a second opinion appointed doctor who records that a patient is not capable of understanding the prescribed treatment or has withheld consent to treatment but the treatment is necessary and can proceed without the patient's agreement.
- Patients could access the independent mental health adviser (IMHA) through the advocacy service. The patients' welcome pack contained information about how to use advocacy services and posters also displayed this information.
- Staff informed patients of their legal rights under the Act.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had completed Mental Capacity Act training. When we spoke with staff they demonstrated understanding of the principles of the Act and they told us the training had been effective. Staff knew people should be assumed to have capacity and may need support with specific decisions. We saw examples of staff supporting patients to make decisions.
- The trust had a MCA policy, which staff were aware of and could refer to if needed. Staff knew where to find this and where to go for advice. There was a named trust contact and staff understood they could make contact or alternatively could talk to the unit manager or one of the multi-disciplinary team.
- The trust had made an application for one patient under the Deprivation of Liberty Safeguards (DoLS) in the last 12 months. However, staff were not clear about how to treat this patient because the local authority had not yet made an assessment, and staff continued to treat him as an informal patient.
- We saw examples of staff discussing how they could best assist and support patients to make decisions.

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

Our findings

Safe and clean environment

- The unit was a single sex ward for male patients. All the rooms were single rooms so no one had to share their room with another patient.
- The ward was equipped with a number of anti-ligature fittings. Ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. There were ligature points in communal areas including the communal bathrooms and in bedrooms, such as some of the window fittings. Staff managed and reduced risks by the use of individual risk assessments. Patients on Meadowbank were not at high risk of trying to harm themselves due to the rehabilitation focus of the unit. The ward had a ligature risk assessment and staff knew where the risks were and how they should manage them.
- The clinic room was clean, tidy and well equipped for carrying out physical examinations. Staff checked emergency medicines daily and listed expiry dates. This included oxygen cylinders, which were full.
- There was no seclusion room on Meadowbank which was appropriate for a rehabilitation ward.
- The ward areas were clean, tidy and well maintained and furnishings were well maintained. Cleaning records and schedules showed that the ward was cleaned regularly. Staff completed environmental risk assessments and audits in relation to health and safety and infection control. The patient-led assessment of the care environment (PLACE) scores for Berrywood Hospital as a whole were 99% for cleanliness and 97% for condition appearance and maintenance. Both scores were above the national average.
- We checked one of the bedrooms, which was in good condition. There were two large kitchens, which were well equipped, modern and clean.

Safe staffing

- The trust had estimated the number of staff needed to provide safe staffing to the unit although the unit manager was not able to say how this was done. As this was a rehabilitation ward, the manager had not needed to deploy additional staff. The unit operated a shift system which ensured there were qualified nurses on duty at all times and sufficient staff to meet patients' needs safely. Staffing levels matched this on the majority of shifts we looked at and staff had taken steps to ensure that periods of absence were covered. Only in one month, September 2016, were less than 90 per cent of nursing shifts covered.
- There was a good skill mix on each shift and specialist workers, including an occupational therapist, an employment co-ordinator and sports instructor, were additional to the shift numbers. The ward manager, psychologist and modern matron provided additional support and oversight.
- There were three vacancies for qualified nurses and no vacancies for healthcare assistants. Data provided by the trust showed that vacancy rates were 52% for nurses between September 2015 and October 2016. The number of healthcare assistants was more than the establishment figure. The manager reported that the service found it difficult to recruit male nurses and support workers and identified this as a significant issue. Patients also raised this as an issue. Sickness rates were slightly lower than the trust average at just over 4%.
- Bank staff, employed by the trust as required, who were familiar with the ward and with patients, worked the majority of shifts uncovered because of sickness and vacancies. Agency workers covered a small number of shifts and the manager told us that they employed familiar staff where possible. Patients and staff told us there were few activities cancelled, including patients' 1:1 sessions.
- A consultant psychiatrist and a speciality doctor provided medical cover to the unit. The consultant psychiatrist also worked with trainee doctors based on site. They also provided out of hours cover to the unit, supplemented by the hospital response team, which included junior doctors and an on-call consultant. The

Are services safe?

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

manager and consultant told us that this enabled them to arrive at the unit in under an hour. The same doctors provided cover in relation to physical healthcare and referred patients to the emergency services or to hospital when appropriate.

- Staff had completed mandatory training relevant to their role. Overall, the unit met the trust target of 90% and all staff had completed safeguarding training. However only 25% of staff had completed training in manual handling and 67% had completed immediate life support.

Assessing and managing risk to patients and staff

- Meadowbank was a locked facility and systems were in place to ensure keys were managed safely and effectively. Patients had an electronic key fob so they could leave and access the building when they needed to in conjunction with their agreed leave arrangements and care plan. Patients also had access to outside areas.
- We looked at four care records on the trust's electronic care record system. All patients had received risk assessments on or before admission. Staff completed used the historical clinical risk management tool, HCR-20, to assess levels of risk in relation to potential violence. Risk assessments were detailed, clear, used historical information to identify risks and staff updated them regularly. They contained information about the patient's goals and considered positive risk taking where possible. Staff used HCR-20s in care programme approach (CPA) meetings and routinely updated them.
- There had been no episodes of staff restraint on patients and no seclusions of patients between 1 October 2015 and 25 January 2017 and there had been no instances staff using rapid tranquilisation with patients in the past 12 months. Staff and the unit manager reported that they would use de-escalation techniques to minimise the use of restraint. Staff said they did not restrain patients on this ward, except in very rare circumstances.
- All staff had received training in safeguarding children and adults and were able to identify where abuse might be taking place. Staff, both qualified and unqualified, were aware of how to make a referral to the local authority and some staff were able to name the trust's safeguarding lead. Staff also reported incidents and

concerns through the trust's electronic recording system. A local authority social worker made regular, usually weekly, visits to the wards to liaise with staff and the unit managers.

- Medicines were securely stored on the unit. Medications were in date and staff checked the temperatures of both the clinic room and the fridge used to store medicines daily. These were within the correct range. All medicines were in date but nurses had opened two bottles of eye drops without recording an opening date, which could pose a risk to patients. Systems were in place for the ordering and disposing of medications. There was a pharmacy on site so medications could be located quickly. In addition, there was an emergency cupboard on site, which staff could access when the pharmacy was not available.
- Patient prescription charts showed there were no missed doses or regular refusals and staff had documented patients' allergies.
- A room was available outside the ward for when children attended the ward.

Track record on safety

- There were no serious incidents on the ward in the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on the trust's electronic recording system. They knew what incidents to report showed us how they would report them. However, one member of staff was not aware of this process.
- Staff reported that they discussed issues arising from incidents through the 'learning lessons' circulation, through e-mails and information on the trust's intranet. This included incidents that had happened in other services within the trust. We also found evidence that staff discussed these in reflective practice meetings facilitated by the clinical psychologist. Staff shared learning, including improvements made as a result of the incident.

Are services safe?

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

- The duty of candour requires providers to be open and transparent with patients when something has gone wrong. The trust had a duty of candour policy, which the service followed. There were no examples of this happening in the past 12 months.

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.

Our findings

Assessment of needs and planning of care

- The trust had a secure electronic recording system. Staff knew where information was stored and showed us how it was organised.
- We looked at four patient records. The multidisciplinary staff team completed thorough, detailed assessments prior to and on admission. They covered aspects of the patient's history and needs together with an assessment of risk. Staff updated these regularly.
- There was evidence of a full physical health check on or shortly after admission and there was evidence that staff monitored patients' physical health regularly.
- The service held Care Programme Approach (CPA) meetings regularly with the patient, their families and relevant professionals. Staff used these reviews to monitor progress, update assessments and set new goals and targets.

Best practice in treatment and care

- The consultant psychiatrist followed guidelines from the National Institute for Health and Care Excellence (NICE) when prescribing medication. There were no patients who had been prescribed olanzapine depot at the time of the inspection, but we saw evidence that staff monitored patients prescribed this medication in accordance with NICE guidelines. The consultant psychiatrist reported that they followed NICE guidelines when prescribing antipsychotic medication and this was seen in prescription charts. The consultant psychiatrist also used other research to make clinical decisions about treatment. We discussed an example concerning the use of a drug to treat a patient with attention deficit hyperactivity disorder (ADHD) and to support them to give up smoking, using the latest research.
- The unit offered 1:1 psychology input for all patients and there was no waiting list for this treatment. A clinical psychologist, assistant psychologist and a trainee psychologist covered this unit and the adjoining forensic low-secure unit. The psychologist also ran a number of groups, for example, on mindfulness and

another on the treatment of substance abuse, which we observed. These groups were open to patients from both wards as well as those supported by the community forensic team.

- Staff focused on developing independence of patients through leisure activities and improving life skills. Staff spent time with patients to maximise their social and leisure interests such as completing a variety of puzzles and games or playing pool; the occupational therapist and an activities co-ordinator helped plan and facilitate these activities. Staff supported patients to buy food and cook all their own snacks and meals in the facilities on the ward. They also worked with patients to gain work competencies and encouraged them to become more independent and self-motivated.
- Staff used the Health of the Nation Outcome Scales (HoNOS) and the brief psychiatric rating scale to assess patients' mental state and monitor their progress. HoNOS is the most widely used routine clinical outcome measure used by English mental health services.
- Clinical staff participated in clinical audits on the unit, such as weekly audits of the national early warning scores and audits in relation to medication, seclusion, risk and ligatures. The junior doctor led this process but nurses and other clinical staff were also involved in this process. A pharmacist conducted weekly audits of medicine management.
- Access to physical healthcare was through the ward doctors who would refer onto other professionals as appropriate and doctors completed a full physical health checks were admission. Allergies were recorded appropriately and nutritional needs considered.

Skilled staff to deliver care

- The team consisted of a ward manager, nurses, a consultant psychiatrist, speciality doctor, psychologists, occupational therapist, activities co-ordinator, an employment advisor and a sports therapist. The unit also had support from a pharmacist. The service had made links with local authority and a social worker visited regularly, although they were not part of the multi-disciplinary team.
- The staff team was a mixture of qualified nurses and unqualified healthcare assistants and therapists.

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.

- Staff received appropriate training at induction and through regular updates. Records showed that mandatory training compliance was high at 90% and that most staff were up to date with the majority of their training. The clinical psychologist also offered regular specialist training to the team to increase the effectiveness of the team and aid workers' personal development.
- Staff reported that they had access to specialist training. This was highly valued by nursing and specialist staff who said it was useful and of good quality. The consultant psychiatrist and speciality doctors received additional study days and an annual budget to access specialist training. Staff gave us examples of additional training completed, such as courses in relation to sex offending, leadership and autistic spectrum disorders. The trust had supported some staff to complete higher education programmes such as complete a degree, undertake a master's degree and a doctorate.
- Staff received regular supervision every four to six weeks. Some staff said they received supervision more frequently than this. However, data provided by the trust indicated that between 1 October 2015 and 30 September 2016, only 74% of staff had received the trust target of ten supervision meetings in a 12 month period. In October 2016, supervision rates were 43% although at the time of inspection they were 94%.
- The manager considered performance issues within supervision.
- Trust figures showed that all staff had received an appraisal in the previous 12 months.

Multi-disciplinary and inter-agency team work

- There were daily multi-disciplinary handovers taking place when shifts changed. Staff meetings were monthly and regularly attended by a range of specialist workers including psychologists and occupational therapists.
- Different professionals within the multi-disciplinary team carried out assessments and they worked well together. Records also showed that the team worked in an effective way.
- Multi-disciplinary CPA meetings took place every six months and other meetings took place as necessary.

- There were good links with external professionals from health and social care agencies, including a multi-agency finance panel, which discussed discharge planning for patients with the local authority social work team.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Adults who are in hospital can only be detained against their will if they are detained under the MHA or if they have been deprived of their liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS). If patients are not subject to the MHA or the MCA DoLS, they can leave the unit, so need to know their rights. Seven of the patients on Meadowbank were detained under the MHA. Records showed that staff informed patients of their rights and status under the MHA by reading their care plans weekly.
- We looked at case records for four patients. MHA paperwork was in date and correct in all cases. We looked at five medication charts all of which had the correct consent to treatment forms T2 and T3 in place and attached. However, one patient did not have a consent form to accompany the T2 form on the electronic record system. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.
- All staff had received training on the MHA and code of practice. Staff we spoke with about the MHA demonstrated knowledge appropriate to their position. Staff were aware of where to go if they required more detailed advice.
- The consultant psychiatrist granted section 17 leave after assessment. Paperwork was in good order.
- Patients had access to independent mental health advocates. There were posters displaying this information on noticeboards in the ward.

Good practice in applying the Mental Capacity Act

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 was one application for a Deprivation of Liberty Safeguard (DoLS) of a patient made in the last 12 months. However, staff were unclear about how to treat this patient, as the local authority had not made an assessment following the application. A detailed mental capacity assessment was in place in relation to the patient's capacity to consent to a formal admission and DoLS application made in his best interest. However, because the local authority had not assessed, the ward continued to treat him as an informal patient.
- One hundred per cent of staff had completed training in the Mental Capacity Act. Staff reported that this training was good and in discussion showed some understanding of the principles of the Act. They were aware that people are presumed to have capacity and may need support to make decisions for themselves. We saw examples of staff discussing how they could best assist and support patients to make decisions.
- The trust had a policy on the MCA and staff knew where to locate it. There were few mental capacity assessments made and staff said that the consultant psychiatrist would be responsible for undertaking them. Patients were assumed to have capacity and it was rare for staff to identify that a patient might lack capacity in a particular area.
- Staff knew where to get advice regarding the MCA and could name the person they needed to contact in the trust. They also said they would speak to the unit manager or one of the other members of the multi-disciplinary team.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- The patient-led assessment of the care environment (PLACE) score for Berrywood Hospital for privacy, dignity and wellbeing was 90%, higher than the national average of 85%.
- We spoke with six patients and observed how staff cared for patients on the unit. Patients told us that most staff treated them with kindness and respect and that their overall experience of living on the ward was positive.
- We saw examples of staff treating patients with kindness and understanding, individually and as part of group sessions.
- Staff talked to us about patients respectfully and showed understanding of their individual needs and goals.
- However, some patients felt that certain staff did not engage in meaningful conversations with them and could be negative when requested to do something such as opening the laundry room door. They also commented that staff did not always inform patients of scheduled appointments and did not always listen to what they wanted to do. This meant they felt staff were dictating to them and not involving them in decisions. They gave us examples of these, including decisions about the ward environment.
- Care plans had details of patient's views and demonstrated that patients had been involved in formulating their plans, including their goals and aspirations. Seven out of eight records we looked at stated that staff had offered them copies of the plan. Patients were also involved in formulating risk assessments and the historical risk management tool HCR-20 which staff reviewed at care programme approach meetings.
- Patients had access to advocacy. The service promoted this through leaflets and posters on notice boards.
- The psychologist ran a carers' group after carers said their needs were not being addressed. This was highly valued and well attended. The team discussed this at length in one team meeting with regular feedback planned by the psychologist at community meetings.
- Patients were able to give feedback through 'I want great care' and 'You said, we did'. Patients scored on a variety of headings by using a computer tablet, which generated an overall score out of five. The service completed this every three months and at the time of inspection, the score was 4.3. All the six patients we spoke with knew how to make a complaint. This process also enabled patients to raise individual issues. Patients had raised concerns about the heating system, staff presence in communal areas and staff prioritising patients over office duties.
- The service had also recently started to use My Shared Pathway to increase patient involvement.

The involvement of people in the care that they receive

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- The average bed occupancy on Meadowbank between 1 October 2015 and 1 November 2016 was 90%. In both May and September this rate reached 100%. This exceeded the 85% recommended by the Royal College of Psychiatrists. There were no out of area placements for this service. The average length of stay for patients was 237 days between 1 October 2015 and 30 September 2016.
- The forensic care pathway was compromised due to the number of rehabilitation beds. The service received the majority of their referrals from the adjacent low-secure Wheatfield unit. The service had identified in November 2016 that patients blocking beds on Wheatfield continued to remain a problem. Staff referred to a bottle neck and that those able to be discharged had nowhere to be discharged to. Staff confirmed that the lack of rehabilitation beds and community placements meant patients sometimes spent longer on the ward than they needed. This caused considerable frustration for patients.
- The trust had reduced rehabilitation services by closing the Brambles in 2015 and Quayside in 2016. This meant that patients requiring intensive rehabilitation were remaining at Wheatfield longer than was needed because of the lack of rehabilitation beds. Meadowbank had attempted to ease this problem by offering rehabilitation during the day to some Wheatfield patients who were ready to be discharged. The trust had plans to increase the number of beds on Meadowbank from eight to 11 and to reduce the number of beds on Wheatfield from 16 to 12.
- The unit had no delayed discharges in a 12 month period from 1 October 2015.
- Staff focused on patients' recovery. The unit worked with other professionals to look at potential placements for patients. The manager attended a multi-agency finance panel for patients ready for discharge.

- There was no evidence of patients not being able to access a bed after returning from leave. The trust had not moved patients onto other wards for non-clinical reasons. All transfers were planned by the multi-disciplinary team with the involvement of the patient.

The facilities promote recovery, comfort, dignity and confidentiality

- The unit had a number of rooms for leisure and therapeutic activities. The clinic room was spacious had all the facilities and equipment needed to undertake physical examinations. There were quiet areas where therapeutic groups could meet or where patients could spend 1:1 time with their named nurse. There were programmes of activities, both on and off the ward, with weekly plans for each patient. There were also rooms where patients could meet visitors including a designated room off the ward, which staff used when children were visiting. The unit had secure garden areas which patients were able to access.
- Patients were allowed to use their mobile telephones when on escorted leave and on the unit. The unit were looking to introduce a cordless telephone so patients could make calls privately and confidentially in one of the quiet rooms on the ward. The current phone was in a communal area and did not ensure privacy. The manager reported that it was rarely used.
- The unit provided patients with a key to their room and they had access to their room at all times. Patients also had access to drinks and snacks.
- The patient-led assessment of the care environment (PLACE) score for food at Berrywood Hospital was 95%, which was above the national average of 90%.

Meeting the needs of all people who use the service

- The unit provided information about services such as advocacy, including IMHAs, the MHA and treatments. There was also information provided about complaints. There were posters on notice boards and leaflets in English were available. Leaflets were not readily available in other languages and there were no notices in other languages about how to access information.

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Good 

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- There was an interpreter service, which patients and carers could access for those who spoke a language other than English. One patient who spoke Arabic was also helped by a member of staff who spoke the same language. Spiritual needs were addressed as required.
- Staff compliance with diversity and human rights training was 100%. There were details of different faiths on the ward and one patient confirmed he was happy about how the service was meeting his religious needs.
- Some staff expressed that there were gaps in services to meet patient's needs. In particular, one of the medical team felt that some patients would benefit from more specialist personality disorder provision.
- There had been no complaints over the previous 12 months.
- Six patients said they were aware of how to make a complaint and would be able to do so if they felt they needed to.
- There was a daily community meeting facilitated by staff and open to all patients. Here, patients could raise their concerns. We found that this was an extremely effective way of responding to patients' issues in a timely manner.
- Staff were aware of how to handle complaints appropriately and how to report them. The service resolved concerns that were raised informally. We saw that this happened in community meetings and 'I want great care'. Managers did not record informal concerns as complaints.

Listening to and learning from concerns and complaints

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.

Our findings

Vision and values

- Staff knew the organisation's values. Not all could articulate the statements in the organisation's leaflets and posters but they were passionate about providing high quality, person centred services.
- Relationships between senior and junior members of the multi-disciplinary team were very positive. Staff felt valued by the unit manager and could give feedback about the service.
- Staff knew who the senior managers were by name and reported that they visited the ward regularly, which they valued. This included the modern matron and the hospital manager.

Good governance

- The manager collected data in relation to supervision, training and appraisals and used it to assess how the team was functioning and address areas of concern. Overall compliance with mandatory training was 90%, which was in line with the trust's target. The manager had a traffic light system in place to ensure they could monitor this effectively. This alerted them to when staff needed to attend refresher course so they kept their training up to date in all areas. The manager reported they had excellent administrative support and had sufficient authority to fulfil their role.
- Supervision rates between 1 October 2015 and 30 September 2016 did not meet the trust's supervision target of 10 supervisions in a twelve month period. The trust provided data that 74% of staff met the trust's supervision target. The manager reported that supervision rates were now higher and further data provided by the trust showed that that this figure stood at 94% in January 2017. We spoke to staff who reported that they received monthly or six weekly supervision. The manager received regular supervision and said they felt very supported by senior managers.
- We looked at shift records for the previous three months. There were sufficient staff on all shifts, qualified workers were always on duty and there was a good blend of skills and experience. The lack of male workers remained an issue, which the manager was attempting to address.

- The manager was looking at some processes to try to ensure staff could spend more time supporting patients. Patients had also raised this issue. It was too soon to measure how managers had responded to their request.
- Clinical staff had started to do clinical audits and the unit manager was trying to include them in more of these tasks. The specialist doctor also undertook a number of audits.
- The unit arranged monthly team meetings where they discussed incidents and complaints, including from other services in the trust. They held daily community meetings for service users to raise issues and staff gave feedback in a timely fashion.
- Staff made safeguarding referrals appropriately to the local authority when necessary.
- Doctors carried out capacity assessments in relation to medication. Staff did not routinely undertake assessments under the Mental Capacity Act but did so when necessary. We saw one assessment, which was very detailed. The manager said that there was no reason in the majority of cases to question that a patient lacked capacity. Staff spent time with patients, helping them to make decisions themselves.
- Staff submitted items to the teams risk register through the unit manager.

Leadership, morale and staff engagement

- The unit manager was highly visible on the ward and offered high levels of clinical support and encouragement to staff.
- Sickness rates were around 4%, which was lower than the trust average.
- Staff knew the whistleblowing policy and were happy to raise concerns with the manager. Staff did not raise any instances of bullying or harassment with us during the inspection.
- Morale within the team was positive and staff told us that their managers supported them to do a very stressful job. Close multi-disciplinary working also enabled staff to feel supported, and develop a common sense of purpose. The multi-disciplinary community meeting held every day ensured this approach focused on patient care. The trust had supported some staff to complete higher education qualifications.

Are services well-led?

Good 

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- Staff reported that they were open and transparent when things went wrong. We did not see any examples of this.
- Medical staff felt that the trust had made decisions without adequate consultation, particularly over the changes to bed numbers on Meadowbank. Medical staff felt that medical management was under-resourced, with the associate medical director and clinical director very thinly stretched.
- The psychologist offered leadership and training to the staff group with assisted therapeutic work with patients across the service in a community setting. There was an imaginative and creative use of limited resources, which included working with another service in exchange for their psychologist doing some work with the staff groups at Wheatfield and Meadowbank.
- The consultant psychiatrist was committed to using the latest research to treat patients. He was also a member of a development group for the mental health and the justice system.

Commitment to quality improvement and innovation

- The service had just joined the Quality Network for Forensic Mental Health Services and the Accreditation for Inpatient Mental Health Services.