# Annesley House

## Quality Report

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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 and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Ratings

| Overall rating for this location | 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 and Deprivation of Liberty Safeguards

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

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

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

# Summary of findings

## Overall summary

We rated Annesley House as good because:

- Wards were clean and comfortable with a homely atmosphere. Environmental risk audits had identified risks and action taken to alleviate these.
- Patients were safe because there were adequate staff; there were no vacancies at the time of our inspection.
- All patients had documented risk assessments and risk management plans. Patients had access to psychological therapies and national institute for health and care excellence (NICE) guidance was evident in care planning. Each patient had a personal timetable of activities.
- Records we reviewed showed staff assessed patients' needs and delivered care based on their individual care plans. On admission each patient had a physical health assessment and records showed patients continued to have physical health checks.
- The hospital kept detailed recordings of incidents when patients needed restraining and the governance group monitored the trends and action plans. The safeguarding and incident reporting processes included monitoring trends and fed back lessons learnt to staff.
- There was a high compliance rate for staff mandatory training.
- The majority of patients and carers we spoke with told us staff were respectful and polite. They felt staff were caring and interested in their well-being. Staff interacted with patients positively and in a kind and caring way.
- All patients told us they had access to good advocacy services. The hospital involved patients in developing and improving services through patient alliance representatives who told us the hospital listened to them and responded to requests.
- There was a clear admission process.
- Staff listened to patients' preferences and patients could personalise their bedrooms with some patients keeping pets. Patients had access to a mobile telephone, could make hot drinks and snacks throughout the day, and had access to a garden.
- All staff said they experienced good leadership at ward and organisational level. All staff had received regular support and managers made themselves available to staff. Staff we spoke with said senior managers were very visible in the hospital and told us morale was good.
- We saw a clear structure of clinical governance at Annesley House through to a regional and national level.
- We saw good examples of a commitment to improve the quality of service provided.

However:

- Staff we spoke with had a variable understanding of the Mental Capacity Act and generally could not tell us the five guiding principles of the act.
- Staff implemented a range of measures to manage violence and aggression, however prone restraints occurred. The Department of Health guidance states prone restraint should not take place.
- Records did not demonstrate that staff undertook a risk assessment before a patient went on section 17 leave, or that their capacity to understand their rights was assessed in line with the Mental Health Act (MHA) Code of Practice.
- A significant number of staff had not completed required food hygiene training.
- Some staff told us they required more specialist training for autism and eating disorders..

# Summary of findings

## Contents

Good

# Annesley House

**Services we looked at**

Forensic inpatient/secure wards. Long stay Rehabilitation wards.

# Summary of this inspection

## Background to Annesley House

- Ms Kelly Johnson Ward is the registered manager for Annesley House.
- Annesley House registered with the CQC in 2010 to carry out regulated activities for; the treatment of disease, disorder or injury, assessment or medical treatment for persons detained under the Mental Health Act and diagnostic and screening procedures.
- Annesley House has 28 beds for women. It offers a low secure service and inpatient rehabilitation services. Patients admitted are stepping down from secure services, or stepping up from the community or rehabilitation. A low secure environment provides treatment to individuals whose risk of harm to others and escape from hospital cannot be managed in other mental health settings.
- Durham ward is a nine-bed low secure ward rehabilitation ward for women with mental illness and or personality disorders. On the day of our visit the ward had six patients detained under the Mental Health Act, two were on civil sections and four detentions were via the criminal justice system.
- Cambridge ward opened in May 2014. Cambridge and Oxford wards are both locked rehabilitation wards. Cambridge ward caters for patients with higher dependency needs who require short structured placements, with intense work to stabilise behaviours to support rehabilitation work. Cambridge ward has eleven beds and Oxford ward has eight beds which were fully occupied. All patients are detained under the Mental Health Act.
- There have been six inspections at Annesley house since registration by CQC. The last inspection was in June 2014 when Annesley House complied in all areas assessed.
- The last Mental Health Act visit to Durham ward occurred in November 2014. An action plan was in place. We found some issues raised had not been fully addressed. Mental Health Act visits took place at Cambridge and Oxford wards in September 2014. Action plans were in place following visits. We found improvements had been made, however some issues were partially addressed.

## Our inspection team

The inspection team consisted of ;

- Surrinder Kaur: Inspection manager CQC.
- One expert by experience
- 3 CQC inspectors
- One clinical psychologist specialist advisor
- One occupational therapist specialist advisor
- One nurse specialist advisor
- Two mental health act reviewers

## Why we carried out this inspection

We inspected this core service as part of our on-going 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?

# Summary of this inspection

Before the inspection visit, we reviewed information we held about these services and sought feedback from four family carers through telephone interviews. During the inspection visit, the inspection team:

- Visited Durham, Cambridge and Oxford wards at the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with fourteen patients.
- Spoke with the managers for each ward.
- Spoke with other staff members including a doctor, nurses, health care workers, advocate, occupational therapist, domestic, health and safety security officer, social worker, psychologist and recovery worker.
- Spoke with patient alliance representatives
- Interviewed the hospital director with responsibility for the wards.
- Held focus groups with three technical instructors, three health care workers, three nurses
- Attended and observed one individual case review (ward round), one hand-over meeting and one community meeting.
- Looked at fourteen treatment records of patients
- Looked at seventeen medicine charts for patients Looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the service say

- Patients told us bedrooms were always clean and tidy there were new carpets, they liked the ward décor and the ward was comfortable with areas to relax.
- They felt safe and their possessions were safe as they had their own bedroom key. However, some patients told us about arguments between patients on the wards, this sometimes made things difficult for them, and they could not relax.
- There were many activities available which included using the gym, library, music, computers, cooking, baking, and art activities.
- Patients told us they felt involved in decisions about their care, they had their say at care programme approach meetings and had a copy of their care plan
- Patients felt listened to and said staff were friendly, caring and supportive. Staff always knocked on the door and were interested in patients.
- Patients told us they were confident staff met their physical health needs.
- They understood about their detention and rights and how to apply for a tribunal. Patients knew how to complain and had support from advocates.
- They had access to hot drinks during the day.
- Patients were involved in restrictive practice groups and patient alliance groups to influence changes in the service.

# Summary of this inspection

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

We always ask the following five questions of services.

### Are services safe?

Good

We rated safe as good because;

- Wards were clean and comfortable with a homely atmosphere. Environmental risks audits had identified risks and action taken to mitigate these.
- Patients were safe because there were adequate staff. There were no vacancies at the time of our inspection.
- All patients had risk assessments and risk management plans.
- Weekly reviews of risk management plans took place with patients. There were detailed recordings of incidents when patients required restraint. The hospital governance group monitored the trends and action plans.
- There were safeguarding and incident reporting processes in place that included monitoring of trends and feeding back lessons learnt to staff.

However:

- Staff implemented a range of measures to manage violence and aggression, however prone restraints occurred. The Department of Health guidance states prone restraint should not take place.
- There was no way to exclude external light from the de-escalation rooms.
- A significant number of staff had not completed required food hygiene training.
- The arrangements for the return of unwanted medication was being clarified with the pharmacy service.

### Are services effective?

Good

We rated effective as good because;

- Records reviewed showed assessment of patients' needs and care delivered in line with their individual care plans.
- There was an assessment of physical health needs on patient admission and evidence of on-going physical health checks.
- A nationally recognised recovery tool assisted in monitoring recovery outcomes
- Patients told us they felt involved in decisions about their care.
- Patients had access to psychological therapies and national institute for health and care excellence (NICE) guidance was informing care planning.

However:

# Summary of this inspection

- Staff we spoke with had a variable understanding of the Mental Capacity Act and were generally not able to tell us the five guiding principles of the Act.
- Recording of risk assessments prior to leave occurring and capacity to understand rights under detention had not been recorded.
- A significant number of staff had not completed required food hygiene training
- Some staff told us they required more specialist training especially autism and eating disorders.

## Are services caring?

Good

We rated caring as good because:

- Patients we spoke with told us staff were respectful and polite; they felt staff were caring and interested in their wellbeing.
- We observed staff interacting positively with patients in a kind and caring way.
- Patients we spoke with told us they had been orientated to the ward and given information about what to expect on admission.
- Patients told us they had access to good advocacy services.
- The organisation involved patients in developing and improving services through patient alliance representatives who told us the organisation listened to them and responded to requests.

## Are services responsive?

Good

We rated responsive as good because:

- There was a clear admission process. Prior to admission a pre-admission assessment was undertaken which included a pre-admission needs formulation and expected patient milestones.
- Staff listened to patients' preferences and patients could personalise their bedrooms; some patients kept pets
- Patients had access to a mobile telephone, could make hot drinks and snacks throughout the day and had access to a garden.
- Each patient had a personal timetable of activities.
- We saw notice boards contained up to date information including the mental health act and advocacy services.
- Patients were aware of how to make a complaint.

## Are services well-led?

Good

We rated well led as good because:

# Summary of this inspection

- All staff said they experienced good leadership at ward and organisational level.
- All staff received regular support and good access to their manager. Staff spoke about the high visibility of senior managers and told us morale was good.
- We saw a clear structure of clinical governance at Annesley House through to a regional and national level. We saw good examples of a commitment to improve the quality of service provided. Within three weeks of completing our inspection, we received detailed information demonstrating action the hospital had taken in response to our verbal feedback.

# Detailed findings from this inspection

## Mental Health Act responsibilities

- Mental Health Act (MHA) training uptake was 97%. There was a plan to update training and policies based on the new MHA Code of Practice. There was access to the MHA and Code of Practice through the hospital intranet and hardcopies kept on each ward.
- All the patients were detained under the MHA. The MHA administrator kept the original detention papers for patients and scanned copies scanned onto the electronic record. On Oxford and Cambridge wards, all patients had their medication authorised on a treatment form (T2 or T3) which was attached to their medication charts. This meant that staff would know the legal authority under which they were providing medication. Electronic notes recorded capacity assessments and consent given to medication. This was an improvement on our previous MHA monitoring visit in 2014.
- The MHA administrator audited the implementation of the MHA and sent clinical staff reminders of key events and timescales that required adherence in accordance with the MHA.
- There was access to legal advice from the organisations legal representatives.
- Two out of five sets of detention papers reviewed on Durham Ward were not scanned onto the electronic records. A lack of chronological scanning of the detention documents made files disorganised. Availability of detention documents provided clinical staff information about the MHA section under which they were providing treatment. The report of the previous MHA monitoring visit in 2014 highlighted this issue.
- Three patients informed us of their consent to treatment and showed us an understanding of their prescribed medication. In the five sets of clinical records, we found three treatment (T2) forms authorising treatment and attached to the medication charts. Staff recorded capacity and consent on the electronic patient records.
- The responsible clinician authorised section 17 leave on the electronic system, this was following discussion about risk in the individual patient reviews by the multidisciplinary team and overall risk assessment and plans being in place. The decision to grant section 17 leave at the exact time of leave was dependent upon the discretion of the nurse in charge who assessed the patient's mood and risk. In one set of notes reviewed we found a clinical entry named `pre-section 17 risk assessment`, with a clinical entry on the patients present mental state prior to leave commencing. We found in four sets of notes reviewed on Durham Ward that risk assessments prior to leave were not recorded. We found in the seven files we looked at on Cambridge Ward that pre-section 17 leave risk assessments and outcomes of leave forms were not completed.This meant that it was not clear how the nurse in charge had made the clinical judgement that it was safe for the patient to go on leave. The report of the previous MHA monitoring visit in 2014 highlighted this issue.
- The responsible clinician authorised leave for up to six months. Conditions of leave did not specify how frequently the leave should be taken. This meant that leave could be open to interpretation by staff. Contingency plans were used for leave, which contained the conditions of leave, what to do if the patient did not return, and the description of the patient. Escorting staff received verbal and written information about risks specific to the patient prior to leave. All staff escorting the patient on leave signed the contingency form.
- Patients received information about their rights three monthly, including access to an independent mental health advocate. We found no record of assessment of the patient's level of understanding of their rights under the MHA. Patients had accessed tribunal hearings, and had legal representatives.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety seven per cent of staff had received Mental Capacity Act (MCA) training. Staff we spoke with had a variable understanding of the Mental Capacity Act and were generally unable to tell us the five guiding principles of the act.
- Managers reported that the mandatory MCA and Deprivation of Liberty electronic learning modules were being introduced to further increase staff understanding.
- Staff had access to the MCA and Code of Practice via the internet; hard copies of the code were present on the wards.
- Staff reported patients received support to make decisions. When the patient was assessed as lacking capacity the multi-disciplinary team would consider their best interests. Staff gave us an example of a recent financial capacity assessment undertaken by a social worker.
- Advice for staff was available from the Mental Health Act administrator, medical staff, and the hospital social workers.
- There were no current Deprivation of Liberty Safeguard applications.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Forensic inpatient/ secure wards | Good | Good | Good | Good | Good | Good |
| Long stay/ rehabilitation mental health wards for working age adults | Good | Good | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

Good

# Forensic inpatient/secure wards

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

## Are forensic inpatient/secure wards safe?

Good

**Safe and clean environment**

- Durham ward provided a low secure environment, commissioned by NHS England. It met contractual requirements about physical security.
- Entry to the ward was via a secured "air lock" entry system. The reception area displayed a list of contraband items for visitors and patients. There was a signing in system for staff to obtain keys to the ward and alarms before entering and leaving.
- Staff were aware of relational security, thisis the knowledge, and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care.
- A staff member on each shift took responsibility to carry out a list of security checks such as counting in cutlery and signed for these.
- The ward layout allowed staff to observe all parts of the ward. Staff were allocated observations to carry out. On the day of our visit, patients' were on hourly general observations.
- The ward was clean and comfortable with a homely atmosphere. The ward had new carpets and there were pictures on the walls. Patient alliance meeting minutes confirmed patients viewed the environment as clean.
- Durham was an all-female ward. All rooms had en-suite facilities
- Wards had ligature risk assessments and identified specific actions to mitigate risks.
- Ligature cutters were stored in the clinic room and office to use in an emergency. These were easily accessible.
- Daily senior manager morning meetings discussed patient safety, security, and ligature mitigation plans. Mangers used team meetings and staff supervision to disseminate information.
- The clinic room was clean and tidy; there was no couch. The ward could access a central clinic area where a couch was available.
- We looked at the resuscitation equipment and emergency drugs. Ward staff recorded they had checked equipment and emergency drugs. Calibration checks had occurred on the sphygmomanometer (a blood pressure machine).
- Charge nurses completed clinic room audits and an audit of the immediate life support bag. Records showed completion of daily and weekly checks such as; the clinic room, fridge temperature, infection control, environment, medicines management and controlled drugs prescriptions.
- Two maintenance men worked on site and carried out work promptly. An on-call system meant they responded to calls within 24 hours. Patients confirmed this and gave examples of maintenance staff repairing a broken door within 15 minutes. An air conditioning unit in the dining room had leaked water and needed a bucket under it; repair took place within a week of reporting.
- There were protocols for managing the environment. Records confirmed that environmental risk assessments had been completed and reviewed annually.
- All staff carried alarms. The inspection team received alarms when visiting patient areas and these were in good working order. During the visit, no situations required activation of alarms.
- There were nurse call alarms in main areas, bedrooms, and bathrooms to summon assistance.

Good

# Forensic inpatient/secure wards

**Safe staffing**

- Durham ward had one consultant at the time of the inspection who also covered two other wards. A new consultant was due to start in December. There were no junior doctors. The consultant had consented to providing interim cover to maintain the continuity of care to patients until the new consultant started. Managers recognised this arrangement put additional pressure on the consultant; however felt it was manageable for the period. Patients we spoke with viewed the consultant in high regard and wanted continuity of care. We found medical cover was sustainable for four months , but not as long term interim position, and recognised the hospital were attempting to minimize disruption to the patients.
- There was a "one in six" on call rota shared with other doctors in the region. When on call, the consultant covered four sites and met the policy target for response to out of hour's calls within one hour.
- Durham ward was able to maintain safe nurse staffing, despite the hospitals recruitment challenges. Staffing was on the risk register with an action plan.
- The hospital used a staffing model, which identified the ratio of staff to patients. Durham ward had 13 whole time equivalent (wte) posts. Five of which were qualified staff. Two staff members had left in the previous 12 months. There were no vacancies at the time of our inspection.
- On the day of our visit, the ward had two qualified nurses and two healthcare assistants, the gender mix being predominantly female. Staff and rotas confirmed the ward worked on this core establishment during the day and registered nurse and two health care workers at night. Staff worked 12-hour shifts that provided continuity of care.
- Bank staff covered 24 shifts over the period June, July, and August 2015. Agency staff covered three shifts. The ward could not cover six shifts with bank or agency during this period. Ward managers were able to use supernumerary staff in these situations. Ward managers told us bank staff were regular staff and sometimes worked as additional staff over and above the cover core numbers.
- Ward managers could request adjustments to staffing numbers in response to dependency needs such as higher levels of observations or special events such as annual sports days. Staff reported managers had supported requests for additional staffing.
- Hospital managers confirmed ward staff planned staffing six weeks in advance. The ward manager reviewed numbers and additional requirements forwarded to the hospital manager to authorise an increase in staffing.
- All staff we spoke with told us there was always at least one experienced member of staff in the ward area and patients we spoke with confirmed this.
- There were enough staff to carryout physical interventions and provide one to one talk time. Patients we spoke with told us they had not had leave cancelled.
- Managers informed us cancellation of leave was collated over the week and the reasons why reported at the senior managers morning meeting. The notes of the morning meeting on 26 August 2015 stated there had been no leave cancellations. Further monitoring occurred through the monthly unit service development and clinical governance meeting
- All staff we spoke with told us they received mandatory training. Figures provided by Partnership in Care for all three wards at Annesley House showed the total compliance for staff having completed mandatory training was 92%. Food hygiene was at 34% and the hospital director told us from September 2015 staff would complete food hygiene training on line and compliance would therefore improve. Immediate life support was at 61% and this was due to new staff not having completed this training yet. A number of these courses were scheduled for September 2015. Managers monitored the uptake of staff training and the governance group received a report.
- Social workers made assessments prior to children visiting to determine their best interests. Families could access a family and children's visiting room situated off the reception area of the hospital.

**Assessing and managing risk to patients and staff**

- The ward dashboards showed all patients had risk assessments and plans in place. These involved completing the Short Term Risk Assessment and Treatability tool (START), and the Historical, Clinical Risk

assessment tool (HCR20), a tool predicting a patient's probability of violence. Risks or physical health needs were documented in the care notes and shared with team members

- Updates of the START assessment occurred every three months and following patient incidents. Senior managers checked this during daily morning meetings for the previous 24 hours.
- Individual case reviews discussed the risk formulations on the HCR 20 forms with patients and a multi-disciplinary team intervention plan identified. A patient confirmed this occurred on a weekly basis.
- The use of a traffic light system helped patients and staff rate the level of risk and plan what patients could do , for example if leave could be taken.
- We saw a folder containing up to date information for bank and agency staff to see at a glance the patients' risks, both historical and current.
- The consultant psychiatrist told us positive risk taking was very much part of the treatment approach and undertaken by the multi-disciplinary team with maximum patient involvement.
- All patients we spoke with said they felt safe and their possessions were safe.
- Staff agreed a patients' property allowance in collaboration with patients. Each person's allowance was dependent upon his or her risk level. Patients would progress from admission to amber then to green. We saw details of the property and item allowance in the patient experience booklet at Annesley House (compiled by patients) and displayed on ward notice boards.
- Partnerships in Care policies were available on the intranet, this included management of violence and aggression. Staff discussed policies in team meetings and supervision. The observation policy had a dedicated electronic training module.
- We found there was a low level of restrictive practice on Durham ward. For the period 1 November 2014 to 30 April 2015, Durham ward had five restraints relating to one patient. One of these restraints resulted in prone restraint and one rapid tranquilisation. Staff used seclusion on one occasion during this period. We saw detailed monthly reports of managing violence and aggression.
- The hospital were implementing the Department of Health (DoH) guidance "positive and proactive care; reducing the need for restrictive interventions" 2014. Restraints had been reduced by using de-escalations techniques and positive behaviour support; a framework for delivering a range of evidence-based supports to increase quality of life and reduce the occurrence, severity or impact of behaviours that challenge" (NHS LGA 2014). The hospital used a positive behaviour model by the Association of Psychological Therapies called RAID (Reinforce Appropriate Implode Disruptive), A philosophy of care that focuses on recovery.. All staff received training in RAID and staff spoke positively about this philosophy; De-escalation was mostly talking and a quiet room or the patient's bedroom would be used.
- Staff and patients told us there were now fewer "blanket" rules. There were boundaries and expectations that were flexible enough to respond to individual patient needs. Patients told us staff were supportive in looking at the least restrictive practice..
- Patients participated in least restrictive practice meetings to influence the reduction of restrictive practices.
- Staff searched patients following return from leave and random room searches were undertaken. This was in accordance with policies, and commissioning contracts. Staff obtained consent prior to searches.
- Safeguarding training was mandatory training for staff. Figures provided by Partnerships in Care for all wards at Annesley House showed 90% of staff had completed the training. Staff could describe different forms of abuse.
- The social worker took the lead in safeguarding but nursing staff could raise alerts out of hours.
- The hospital had good links with the Nottingham multi-agency safeguarding hub,(MASH) and made safeguarding alerts and referrals to them. Joint meetings with the MASH occurred to review the safeguarding referrals. The MASH team provided advice and support to the hospital. The social worker kept a log of all safeguarding concerns raised.
- A manager told us safeguarding alerts had fallen dramatically over the past two years and said this fall was due to changes in leadership. Staff were now more alert to ward dynamics and worked more collaboratively with the patients. We saw the safeguarding adults report from December 2014 to April 2015 this showed staff had made 10 safeguarding alerts at Annesley House.
- The process for maintaining the safety of patients included a number of different review processes to

monitor concerns. Managers told us they were confident there were good levels of reporting and staff had a good understanding of the threshold for reporting and would check with senior staff.

- The ward used a safeguarding tracker to highlight both concerns and referrals. The daily senior managers' morning meeting, individual case reviews, and multi-disciplinary team meetings all reviewed safeguarding concerns.
- Governance arrangements required the social worker to produce a safeguarding report for the regional clinical governance meeting. Minutes we saw of the regional clinical governance meeting confirmed this.
- Health care workers reported any concerns to a staff nurse or more senior person if necessary. They wrote down their concerns, the qualified nurse completed the safeguarding referral form and this was sent to the social worker.
- Patients told us there were "good rules" on the ward and they had not experienced any aggression from other patients.
- We reviewed the arrangements for medicines management. The hospital kept controlled medicines in locked cupboards and two qualified nurses checked and dispensed these drugs. There were records of all controlled drugs in the controlled drugs book. Two staff members checked Benzodiazepine medicines (one of who was a registered nurse). All emergency medicines were present and in date.
- The hospital manager told us the pharmacist monitored the stock of medicines. Contract reviews were undertaken with the pharmacy. Medicines management audits and pharmacy input were discussed at the Partnership in Care regional governance meeting in August 2015. Partnerships in Care registered managers and the pharmacist were meeting in September 2015 to address concerns and to make improvements.

**Track record on safety**

- The number of serious incidents reported was low. Two serious incidents occurred between May 2014 and May 2015 on Durham ward. Staff from other areas used a root cause analysis to investigate incidents. Reports made recommendations and the hospital governance committee monitored the implementation of the actions.

**Reporting incidents and learning from when things go wrong**

- All staff we spoke with were able to explain the process for reporting incidents and what to record. Health care workers told us they would report incidents to the nurse in charge. Staff completed an incident form on the electronic system and information was referenced into the patient's notes
- Ward managers checked the report and they discussed any incidents at the morning meeting. Examples of incidents reported included, assaults, medicine errors, managing violence and aggression and self-harm.
- Learning from incidents took place during senior managers morning meetings, shift handover, supervision, and reflective practice meetings and by email.
- We saw minutes of Annesley House service development and clinical governance meetings and noted a review of incidents and lessons learnt was a standard agenda item.
- Most staff we spoke with could give examples of learning from incidents and changes in practice made because of this learning.
- The hospital mangers gave a detailed summary of action taken in response to the coroner's report of the patient death. Staff we spoke with consistently reported changes made because of this learning such as:
- Training in the National Early Warning (NEWS) a scoring system for physical health assessment.
- All nursing staff had received immediate life support training (ILS).
- A physical health care worker and regional registered general nurse (RGN) provided physical healthcare assessments.
- Staff reported they had de-briefing sessions following incidents, recorded as supervision. Support occurred in a variety of ways for example distressed staff members could move to another ward where appropriate. Support from psychology, the ward manager and advice from the consultant psychiatrist and access to a help line was available.
- Patients received de-briefing following an incident and staff recorded this in the patient's care notes.

## Are forensic inpatient/secure wards effective?

Good

# Forensic inpatient/secure wards

(for example, treatment is effective)

Good

**Assessment of needs and planning of care**

- Assessment of needs and planning of care began prior to admission. The pre assessment report contained the initial needs formulation (a plan of treatment). When the initial care plan was agreed, the formulation was included in the plan. We note some staff told us it would be helpful to have a formulation tab in the electronic notes system so the formulation could be quickly located.
- Detailed assessment of patient needs and care occurred subsequently. Five case note reviews identified individual care plans, clear goals and interventions were recorded.
- Patients had their pre-admission needs formulation with expected milestones reviewed with them during individual case reviews and care programme approach (CPA) meetings. Research underpinned milestones. Where anticipated milestones were not reached, the possible reasons for this were analysed.
- We saw the wards used a nationally recognised good practice recovery tool called, "My shared pathway." This was a way of planning, following and managing an admission through secure services, looking at recovery, health, relationships, safety and risk. This enabled monitoring of progress and outcomes.
- Records showed there was an assessment of physical health needs on patient admission and ongoing physical health checks. The ward used the national early warning system (NEWS); it is a scoring system for physical health assessment. There was a flow chart in each clinic room showing the process to follow. The consultant asked about physical health scores at the senior manager's morning meeting.
- Patients told us they had appointments with the dentist, opticians, and regular blood pressure and weight checks.

**Best practice in treatment and care**

- National institute for health and care excellence (NICE) guidance was evident in care planning and underpinned working with people with a personality disorder with least use of medicines. Prescribing followed British National Formulary (BNF) guidelines. Staff reported there was good liaison between pharmacy and referrer.
- Patients had access to clinical psychology, dialectical behaviour therapists (DBT, provided a specific type of cognitive-behavioural therapy, recovery workers, occupational therapists, and technical instructors. Individual and group treatment sessions occurred. Partnerships in Care had recently appointed a speech and language therapist and dietician.
- There was a psychologist vacancy at the time of the visit and recruitment had taken place. In the meantime, the ward received on-going support from the lead psychologist and assistant psychologist.
- Assessment took place on admission and subsequently of the patients need for psychological therapies. The hospital governance group reported 100% access in April 2015 to psychological therapies.
- The tools used to measure patients recovery outcomes included health of the nation outcome scales (HoNOS) and EuroQol (a standardised instrument for use as a measure of health outcome). HoNOS is a routine clinical outcome measure recommended by the English national service framework for mental health that covers twelve health and social domains and enables clinicians to build up a picture over time of patients' responses to interventions.
- The Association of Psychological Therapies awarded Annesley House RAID centre of excellence (Reinforce Appropriate Implode Disruptive - A philosophy of care that focuses on positive behaviour and recovery). The award was based on policies reflecting the language of RAID, all staff receiving training in RAID. Staff spoke positively about this philosophy.
- Psychologists worked with new patients on admission to complete psychological assessments including Clinical Outcomes in Routine Evaluation ( CORE), the brief symptom inventory (patient self-reporting inventory), and the personality assessment inventory. Use of a structured interview format covering strengths and needs and part of the shared pathway booklet occurred, for example, risk actions to identify what the patient's perception of their risks were.
- The occupational therapy service saw patients within three days of admission. The team used standardised assessments such as the model of human occupation

screening tool. Following a baseline assessment, an assessment occurred every six months to provide a measure of patient progress. We saw an evaluation of sessions had been completed

- Staff participated in various audits including a brief audit on the completion of the short-term assessment of risk and treatability tool (START) in 2014. This identified that STARTs were being completed as per the guidelines and were up to date, there were some areas which could be improved.
- Participation in 'The National Audit of Schizophrenia had taken place and the results were pending.
- The hospital took part in national audits and were awaiting the results for example the Anti-Psychotic Prescribing with People with Learning Disabilities, Long Term Management of Self Harm , National Suicide Audit, and the use of sodium valproate. Infection prevention leads used national infection prevention audit tools.

**Skilled staff to deliver care**

- Recently appointed staff we spoke with told us they had enjoyed their induction. This included a total of two weeks in the classroom covering areas such as health and safety, managing violence and aggression (MVA) and breakaway. They also worked as a supernumerary member of staff for one week. They completed a folder of learning which managers signed off on successful completion of their probationary period. They said the induction and learning from the team helped them to manage the patients.
- The minutes of staff consultative committee in April 2015 stated that any new health care workers from June would work through the care certificate workbook that replaced the current work booklet.
- A newly qualified social workers undertook a three-month probationary period and an induction to the role of the social worker at Annesley House. Team leaders provided support and supervision Following completion of the probationary period, social workers started their assisted and supported year in employment (AYSE). AYSE is a government recommendation introduced in September 2012 for all social workers. Allocation of study time occurred fortnightly. There had been opportunities and funding to attend courses and enable university modules.
- Bank and agency staff were familiarised with standards and procedures for observation; the hospital received information about staff skills and experience prior to using agency staff members. A ward manager told us the agency they used guaranteed a similar level of induction to that undertaken by permanent staff joining Partnerships in Care.
- The hospital had a format to check experience, skills, and training the agency staff had received and encouraged staff and patients to feedback on the work of agency staff. Poor performance of an agency staff member resulted in disengagement. A patient we spoke with gave an example of reporting a concern about an agency worker and they had not worked on the unit again.
- All the staff we spoke with told us they received good regular managerial and clinical supervision, attended regular reflective practice sessions and had an appraisal in the last year.
- Information provided by Annesley House stated they were 92% compliant for supervision and 100% for staff appraisals within the last year. Reflective practice sessions occurred on each ward on a three weekly basis.
- Four staff told us they had not received training in specific clinical conditions such as eating disorders, autism, and schizophrenia. A four patients and carers had also mentioned a lack of skilled staff in working with people with eating problems. We spoke with the hospital director and they told us Annesley House was not a specialist eating disorder unit but would look into this. They said a wide range of distance learning training was available to staff including eating disorders, Asperger's syndrome, and mental health.
- Occupational therapy staff we spoke with felt they did not understand sensory issues enough to identify and meet any such needs. (The NICE Guideline 142 issued June 2012 notes "People with autism also commonly experience difficulty with cognitive and behavioural flexibility, altered sensory sensitivity, sensory processing difficulties, and emotional regulation difficulties" and states assessment of challenging behaviour should include the physical environment, including sensory factors).
- There were three qualified dialectical behaviour therapists (DBT) and an advertisement had recently been placed informing staff of more DBT training opportunities. Managers told us they wanted to encourage as many staff as possible to train as therapists. DBT is a form of talking psychological therapy.

- As part of staff continuing professional development DBT awareness sessions had been offered to all staff.
- Durham ward had regular team meetings.

**Multi-disciplinary and inter-agency teamwork**

- The multi-disciplinary team included the ward manager, responsible clinician, occupational therapist psychologist, and social worker. There were regular meetings to plan and review patient care.
- Team meetings included a daily team meeting attended by the senior team on site and staff nurses. There was a weekly individual review by the doctor plus a monthly multi-disciplinary team meeting with the patient for an individual care review (ward round). Monthly meetings included all members of the team and others the patient wished to invite.
- A care programme approach (CPA) meeting occurred 12 weeks after admission that included external services and the patient's family with consent of the patient. CPA meetings occurred every six months subsequently. An internal CPA process ran alongside the individual case review with an extended meeting every three months to review CPA actions. We saw a timetable of meetings displayed on the ward notice board.
- Staff reported the doctor was very approachable, open and included health care workers and recovery workers in the team. Staff who attended individual case reviews told us they felt able to put ideas forward and their contributions accepted. For example, if a patient wanted to progress with their leave they would be asked about possible risks in this area.
- A review of the contract between Annesley House and the GP service had resulted in weekly GP visits. The GP received the same information governance training as Partnerships in Care staff in order to input into to the hospitals electronic patient records. To maintain continuity of care exchange of electronic visit records occurred between the GP and hospital.
- Social workers based at Annesley House maintained links with other teams out of area. The frequency of contact varied according to distance from referring authority.

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

- Mental Health Act (MHA) training uptake was 97%. There was a plan to update training and policies based on the new MHA Code of Practice.
- All patients on Durham ward were detained under the MHA. The MHA administrator kept the original detention papers for patients. The MHA audited the implementation of the MHA and sent clinical staff reminders of key events and timescales that required adherence in accordance with the MHA.
- There was access to legal advice from the organisations legal representatives. There was access to the MHA and Code of Practice through the hospital intranet and hardcopies on the ward.
- Two out of five sets of detention papers reviewed were not scanned onto the electronic records. Lack of chronological scanning of the detention documents made files disorganised. This meant that clinical staff might not be fully aware of the legal authority under which they were providing treatment. The report of the previous MHA monitoring visit in 2014 highlighted this issue.
- Three patients informed us of their consent to treatment and showed us an understanding of their prescribed medication. One patient stated that side effects of medication had not been discussed. In the five sets of clinical records, we found three treatment (T2) forms authorising treatment and attached to the medication charts. Staff recorded capacity and consent on the electronic patient records.
- The responsible clinician authorised section 17 leave on the electronic system, this was following discussion about risk in the individual patient reviews by the multidisciplinary team and overall risk assessment and plans being in place. The decision to grant section 17 leave at the exact time of leave was dependent upon the discretion of the nurse in charge who assessed the patient's mood and risk. In one set of notes reviewed we found a clinical entry named `pre-section 17 risk assessment`, with a clinical entry on the patients present mental state prior to leave commencing. We found in four sets of notes reviewed that risk assessments prior to leave were not recorded. Nor was the outcome of leave. The report of the previous MHA monitoring visit in 2014 highlighted this issue.
- The responsible clinician authorised leave for up to six months. Conditions of leave did not specify how frequently the leave should be taken. This meant that leave could be open to interpretation by staff.
- We found records for a "contingency plan for leave" which contained the conditions of leave, what to do if the patient went absent, and the description of the

patient. Escorting staff received verbal and written information about risks specific to the patient prior to leave. All staff escorting the patient on leave signed the form.

- Patients received information about their rights three monthly, including access to an independent mental health advocate. We found no record of assessment of the patient's level of understanding of their rights under the MHA. Patients had accessed tribunals and had legal representation.

**Good practice in applying the MCA**

- Ninety seven percent of staff had received Mental Capacity Act (MCA) training. Staff we spoke with had a variable understanding of the Mental Capacity Act and were generally unable to tell us the five guiding principles of the act.
- Managers reported mandatory MCA and Deprivation of Liberty Safeguards electronic learning modules were being introduced to further increase staff understanding.
- Staff had access to the MCA and Code of Practice from the company intranet and hard copies of the code were present on the wards.
- Staff reported patients received support to make decisions. When the patient was assessed as lacking capacity the multi-disciplinary team would consider their best interests. Staff gave us an example of a recent financial capacity assessment undertaken by a social worker.
- There were no current Deprivation of Liberty Safeguard applications.

## Are forensic inpatient/secure wards caring?

Good

**.Kindness, dignity, respect and support**

- Patients were complimentary about their relationship with staff. They told us staff were caring, respectful and polite, they knocked on doors before entering bedrooms. They said staff always had time for patients. Patients described staff as being fabulous or fantastic and praised them highly. Patient alliance meeting minutes confirmed this.
- The majority of family carers we spoke with were also very positive about the approach of staff. Describing staff as brilliant and displaying humour, and professionalism with both family and carers and patients felt very relaxed with them.
- Staff we spoke with had an understanding of individual patient's needs.
- During our inspection, we observed staff interacting positively with patients in a kind and caring way. We saw a dog around the building for patients to play with. Three patients using a Wii dance programm with staff observing from a distance. We saw patients in the garden having fresh air.
- We saw interaction between patients and the consultant that was relaxed, demonstrated equality and was respectful.
- We saw an altercation in the garden that staff responded to swiftly and quietly by moving a patient to another area.

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

- When admitted to the wards all new patients had an identified peer who acted as a "buddy" to introduce them to the ward. The patients received an introduction to their primary nurse and saw the responsible clinician. The clinical team agreed the level of observations on admission.
- A booklet was available giving information about Annesley House and members of the multi-disciplinary team introduced themselves and explained what treatments they offered. One patient said the nurse in charged showed her around the ward and explained her rights when admitted.
- We saw an information booklet containing information about Annesley House prepared by patients. The booklet included information about RAID (Reinforce Appropriate Implode Disruptive). The booklet explained each ward had a RAID representative and gave details about what RAID meant. The booklet gave examples of red and green (negative and positive) behaviours.We saw posters displayed on ward notice boards giving information about RAID.
- The patient information booklet included details of the patient alliance and the role of the representatives. Information about psychology and occupational

therapy services were included in the document as well as detailed information about ward routines and expectations. Views of patients about their experience at Annesley House were also included in the document.

- We found good access and uptake of advocacy services. All patients we spoke with told us they had good access to advocacy services.
- The advocacy service visited all wards once a week, and spoke to all of the patients. The advocates attended CPA meetings and individual case reviews when requested. Staff were also willing to meet the advocate outside of these times to avoid waiting for formal meetings. The advocacy service provided the independent mental health advocacy service (IMHA). They spoke to individual managers on a weekly basis and there was a meeting with the management of Annesley House on a quarterly basis.
- The advocacy service told us patients felt involved in their assessment, developing their care plans and risk management plans and reviews. Patients told us they felt very involved in their care and had copies of their care plans. Patients said they were listened to in care programme approach meetings (CPA), which involved family members and advocacy. We saw care plans for life skills, physical health, relationships, safety, and risks insight. The language in the care plans was a mixture of the patient voice and professional language.
- The social worker managed the approval list for visitors working with patients, relatives, and ward staff. They spoke to the family of the patient, agreed, and updated necessary records and care plans.
- The process for establishing if the patient consented to family members receiving information was to discuss this with the patient and record verbal approval in the electronic care notes. Prior to home leave, the social worker completed an environmental risk assessment and established relationships with relatives.
- Whilst three relatives told us, they were involved and attended or were invited to CPA and other meetings where they had been able to contribute, one family carer shared concerns about the level of involvement they had in their relatives care.
- We discussed carers concerns about communication with the hospital managers. They told us this was a priority for the organisation for 2015-2016. Partnerships in Care had just drafted a carer involvement strategy; consultation took place at Annesley House at the beginning of August 2015 and some suggestions for change were made. The current process included discussion with the patient before their CPA meeting to determine if the patient wanted family members present. Staff recognised the difficulties for families if the patient refused. When patients refused staff worked hard to find a solution that worked for everybody. They explained other action taken to improve links with families included arranging for a relative to visit the ward to see where their family member was staying by prior arrangement with staff and patients.
- Open days had been arranged for families to visit but these had not generally been well attended. Usually visits worked better on a one to one basis; they were looking at less formal arrangements for families to meet staff and see the environment.
- Partnerships in Care had produced an information booklet “Working in Partnership with Families, Friends, and Carers” which included details of visiting and contacting the organisation if there were any concerns.
- We spoke with patient alliance representatives who told us there was a regional meeting every two months, which included representatives from other units within the Partnerships in Care organisation. In addition to patient alliance representatives, the hospital manager, regional governance manager, a ward clerk and two health care workers attended the regional meeting.
- One patient representative said they got people together after meal times. The agenda included such topics as restrictive practices and what they would like to change, living areas, catering, protocols and policies.
- The patient representatives told us they definitely felt listened to. For example, patients requested a new kitchen. Patients were involved in the planning of the new kitchen and installation took place within two months of the request. They also told us patients had requested an increase in the shopping budget and the hospital responded by giving them more than they had requested.
- We reviewed the patient alliance folder, which contained three sets of minutes. These showed patients reported they were enjoying arts and crafts, the advocacy service was useful, and there was discussion about social activities.
- The patient satisfaction survey report for 2014–2015 received nine responses from the whole hospital. An action plan was in place to address the emerging themes such as information, food and access to computers.

Good

# Forensic inpatient/secure wards

**Are forensic inpatient/secure wards responsive to people's needs?**
(for example, to feedback?)

Good

**Access and discharge**

- The ward admitted patients from the Midlands area and nationally from NHS England commissioning arrangements.
- All new referrals to the ward were brought to the morning senior manager meeting and it was agreed which member of the team would undertake the initial assessment. A member of the team would always go and assess within five working days.
- An initial needs formulation was included in the pre-assessment report. The senior manager morning meeting reviewed the pre assessment report and made the decision to accept or refuse the referral. Patient mix and ward dynamics were considered as part of the decision making process. The ward could refuse to admit a person referred if the team felt the referral was not appropriate.
- We undertook a review of one emergency patient admission to Durham ward who had previously been on a ward at Calverton Hill. Documentation showed that an emergency placement was appropriate given the circumstances. Subsequent management had led to fewer incidents in comparison to their previous placement. Records reviewed showed completed assessments with on-going reviews. The service was developing an understanding of the patient's needs and communication with the patient's family occurred.
- Figures provided by Partnerships in Care showed bed occupancy on Durham ward for the period 1 November 2014 to 31 March 2015 was 55%.
- Patients accessed their own beds on return from leave. No patients were moved between wards, unless it was part of their planned pathway to step down to a locked rehabilitation unit. Following their stay on the low secure unit, patients were considered for other placements within or out with Partnerships in Care in consultation with NHS England commissioners.
- Annesley House reported no delayed discharge for the six-month period 1 November 2014 to 30 April 2015. Discharge planning was discussed during care programme meetings. Patients visited placements to consider options when nearing discharge.

**The facilities promote recovery, comfort, dignity, and confidentiality**

- Patients on all wards had access to rooms, used for therapy, activities, and interviews. Rooms off wards were utilised.
- Patients had access to the well-maintained communal garden and smoking garden.
- We saw the garden had personalised by patients. We saw a 'fairy garden' displaying birdhouses made by patients; some patients had grown their own produce. There was also access to a tennis court and large green space for sports.
- Arrangements for smoking were hourly between 8.00am and 8.00pm
- We saw there were two visitors' rooms and visiting was by appointment.
- All patients had access to mobile telephones either their own or provided by the ward based on an individual risk assessment. There was also access to telephones in quiet areas on the ward. Partnerships in Care had a policy regarding use of telephones, which involved a contract with the patient on their use. On admission, the patient received a unit phone ,with progressing risk levels the choice of phone changed. When assessed as amber patients received a smart phone. Random checks occurred on mobile phones for abusive receipt of texts. Patient-to-patient texts or pictures of staff or patients were not allowed. Patients were expected to use the internet appropriately.
- Patients could personalise their bedrooms and patients had access to their bedrooms during the day unless there was a risk.
- Patients could make hot drinks during the day. Snacks were available in between meal times.
- The 2014/15 patient survey had a response rate of nine from the whole hospital, of these 56% said that the food was fair or poor. This was being addressed in the action plan.
- Patients were offered more than 25 hours a week of activities as part of the commissioning service contract.

The hospital audited the uptake of activities. We saw up to date information about patient activities displayed on the notice board, and an individualised patient planner for each day in notes reviewed.

- Patients said they participated in a range of activities such as dog walking, attending therapy groups, and arts and crafts. Patients had access to social activities such as bowling and shopping.
- Two full time recovery workers were available five days a week to support all three wards at Annesley House and covered six days out of seven including either Saturday or Sunday.
- Occupational therapists and technical instructors provided an individual timetable of activities that they evaluated with the patient on a quarterly basis. Activities included groups such as anxiety management, a breakfast club, creative writing, drama, right mind, fitness sessions, community skills and a hobbies group. Patients could also attend coping skills and problem-solving groups, had access to real work opportunities and there was a drugs and alcohol group based on a 30 week model. The care plan was developed during programme planning week which allowed involvement of members of the multi-disciplinary team to be involved in this process
- Staff reported concerns that weekend working to provide activities had not worked. For example, one nurse told us patients were not keen on formal activities at the weekend andactivities were ad hoc. Technical instructors worked at the weekend. This meant there were less staff hours during the week and it was difficult to ensure patients had access to the expected level of activities. The hospital manager told us the occupational therapy service had planned to try a new approach on the next programme due to start at the end of September at weekends.

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

- We saw notice boards containing up to date information including the Mental Health Act and independent mental health advocacy. We saw evidence of patient involvement with these display boards. We saw information that gave an overview of treatments, healthy lifestyles, advocacy services, CQC, how to complain, RAID (with a clear explanation of both red and green behaviours) and weekly activities. However, we did not see information relating to smoking cessation or common mental health problems.
- Leaflets were not available in other languages on the ward, they could be ordered in the language required when needed.
- Staff respected patients' diversity, religious and cultural needs, and human rights. For example, a ward manager told us they had obtained an Imam at the request of one patient and had links to the church in Annesley. They had arranged for a patient to attend church.

**Listening to and learning from concerns and complaints**

- Partnerships in Care reported two complaints for Durham ward for the 12-month period prior to May 2015 of which one was upheld.
- We saw complaints leaflets were available. Staff reported complaints were often resolved at a local level. A ward complaints book recorded complaints made and reviewed at multi-disciplinary team meetings. The ward staff investigated the informal complaints, managers investigated formal complaints.
- There was a weekly community meeting which also gave the opportunity for patients to raise concerns the ward could action.
- Health care workers we spoke with were able to explain what they did if a patient wanted to make a complaint. Records showed complaints were also recorded in the electronic patient records. Staff reported patients received information on how to make a written complaint. Patients we spoke with were aware of the complaints procedure.
- We saw "concern line' posters, and "talk to us" posters displayed on the wards. The organisation had a staff complaints booklet that answered questions staff may have had about complaints.
- We saw a review of complaints was a standing item on the Annesley House service development and clinical governance meeting. The notes for the May 2015 meeting highlighted there were no formal complaints. We saw minutes of the regional service development and clinical governance meeting in which both formal and informal complaints were monitored. Feedback on learning from complaints occurred through training and reflective practice.

Good

# Forensic inpatient/secure wards

## Are forensic inpatient/secure wards well-led?

Good

### Vision and values

- Many of the staff we spoke with were not completely clear about the organisations vision and values. For example, we were told there were five guiding principles which included integrity, people and teamwork. One member of staff told us told us the organisations values were on the intranet.
- All staff we spoke with were clear about their wards vision and purpose.
- All staff spoke about the high visibility of senior managers. One health care worker told us senior managers visited the ward at least once a week. Staff told us the chief executive officer visited once a year. The regional director went once a month on to the ward and staff reported they were very approachable for both patients and staff.

### Good governance

- We saw comprehensive minutes of the regional service development and clinical governance meeting. These showed a range of governance areas were reviewed. Agenda items included governance, risk management, staffing, and staff management including education and continuing professional development. Other items included information management, effectiveness and outcomes, clinical audit and patient and carer involvement.
- Weekly reviews of all ward dashboards occurred. The detailed dashboard included areas such as care planning, community meeting, and patient sessions with their primary nurse and access to psychological therapies. We saw minutes that showed the monthly Annesley House and regional service development and clinical governance meetings reviewed the ward dashboards and any required actions identified. Board governance committees included an overview of risks and actions plans and provided recommendations and advice. Managers shared lessons learnt with staff.
- We looked at Durham ward dashboard and it included items such as whether all patient details had been completed, details of Mental Health Act status, access to psychological therapies, dates of individual case reviews and care programme approach meetings, numbers of seclusions and incidents.
- Managers reported there were a number of key performance indicators they had to report on, monitoring of these took place by the hospital, regional and board committees. These included commissioning for quality and innovation (CQUIN) targets, contract performance and monitoring, service development and the clinical audit programme.
- Regular audits took place that scrutinised adherence to the CQUIN framework. The areas covered in the fourth quarter for 2014/2015 included collaborative risk assessments, friends and family tests, needs formulation at transitions, reducing premature mortality in people with severe mental illness and quality dashboards for specialised services.

### Leadership, morale and staff engagement

- Without exception every member of staff we spoke with told us they experienced good leadership at a ward and organisational level. They all received regular support and good access to their manager.
- We heard many positive comments from staff about how they felt about their work and colleagues. For example, one member of staff said they loved their job; the ward could be challenging because of patient mix but therapeutic relationships were a staff strength. Other staff told us morale was good. They said there was some stress but this was normal and understandable and they could handle it.
- Staff told us how they felt things had changed and improved. For example, one member of staff told us the staff group were happy and they could really see a turnaround. Staff reported that morale had been terrible and there had been a lack of structure and poor supervision but there was now a new approachable leadership style and managers were willing to listen. Staff described working in supportive teams and being able to ask if they were unsure. Staff described their work as sometimes being stressful especially when one to one or two to one interventions were required and this had an impact on other patients on the ward.
- Staff sickness on Durham ward was very low. Staff sickness at Annesley House from February to July 2015

ranged from 3.07% in February to 1.28% in July. The lowest rate was in May at 0.51%. Figures from November 2014 to July 2015 showed a decreasing trend in sickness absence.

- To retain staff Partnerships in Care had a range of initiatives that included good support systems, a preceptee academy, commitment to learning and development, recognition of good practice and staff excellence. Proposed initiatives included payment of annual NMC registration, extension of the notice period for key staff and a strategy regarding supporting revalidation.
- All staff we spoke with told us there was an open culture and felt confident to whistle blow, raise a grievance or make a complaint. They told us whistleblowing policies and procedures were available on the company's intranet. Staff told us they would raise any concerns through their team leader or registered manager. They felt their manager would support them.
- Monthly "meet the director" sessions occurred to enable staff to tell the hospital director what was good and what required improvement. Consequently, all staff had met the hospital director. The director kept notes of the meetings and was going to publish staff suggestions for change.
- We saw posters advising staff how they could communicate directly to the board. A "concern" line telephone number enabled staff to report concerns.
- Some staff were able to tell us that the duty of candour was being completely open and honest with everybody and apologising when things went wrong but others were less clear. The hospital director informed us they joined the morning meeting to keep a watchful eye on situations where duty of candour could apply. Advice was available to staff.

**Commitment to quality improvement and innovation**

- Durham ward had used the Department of Health (DOH) guidance on promoting the development of therapeutic environments and minimising all forms of restrictive practice to review practice on the ward. The DoH had visited and commended the organisation for what they had done. Key staff received invitations to join the national restrictive practice group established by the DoH.
- Annesley House has successfully completed the self and peer-review parts of the Quality Network for Forensic Mental Health Services annual review cycle. The report (March 2014) stated that Annesley House had met 88% of low secure standards.

# Long stay/rehabilitation mental health wards for working age adults

Good

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

## Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

**Safe and clean environment**

- There were blind spots on both wards. Staff were aware of these and conscious of patient risk. Staff managed the risks using mirrors, increased observations, locking doors, or providing patients with bedrooms nearer to communal areas.
- The ligature risks were adequately mitigated. Ligatures are cords that can be tied to objects in order to self-harm. Both wards had completed ligature risk assessments and had identified actions to mitigate the risks. Daily senior manager meetings discussed ligature risk management plans and information from these were disseminated in team meetings and staff supervision.
- Ligature cutters were easily accessible and were stored in the clinic room and office to use in an emergency.
- Both wards were for females only and provided en-suite facilities.
- The clinic rooms on both wards were clean but very small, accommodating no more than two staff. Resuscitation equipment and emergency drugs were checked weekly and signed for. There was no examination couch however; the wards could access a central clinic area where a couch was available.
- Cambridge ward had one seclusion room with a lock, integral blinds, en-suite facilities and was temperature controlled. There was no hatch in the door so staff had to open the door to offer the patient food, drink, and medication. This could cause delays if a team of staff was required to enter the seclusion room. There was no seclusion room on Oxford ward.
- There were two de-escalation rooms on Cambridge ward. De-escalation rooms are low stimulus rooms, where a patient could go to calm down and have one to one talk time with staff. The rooms had carpets but did not have blinds or curtains at the windows to block the sunlight if required. The managers confirmed seclusion did not happen in the de-escalation room and this was verified by a review of the seclusion documentation.
- The wards were clean and comfortable with a homely atmosphere. The wards had new carpets and there were pictures on the walls.
- Environmental risks were identified and managed. Environmental risk assessments had been completed and reviewed annually for both wards. Identified hazards had measures listed to mitigate the risks.
- Charge nurses completed environmental audits. Records showed completion of daily and weekly checks of the clinic rooms, fridge temperatures, infection control, ward environment, medicines management and controlled drugs prescriptions.
- Two maintenance staff worked on site and responded to calls and emergencies within 24 hours through an on-call system. Staff and patients said environmental repairs occurred swiftly.
- All staff carried alarms. The inspection team received alarms when visiting patient areas and these were in good working order. During the visit, no situations required the activation of alarms.
- There were nurse call alarms in main areas, bedrooms, and bathrooms to summon assistance.

**Safe staffing**

# Long stay/rehabilitation mental health wards for working age adults

Good

- The hospital used a staffing model, which identified the ratio of staff to patients. Cambridge ward had 17 whole time equivalent (wte) staff in April 2015; it had three leavers in the previous 12 months. Oxford ward had 13 wte staff and no leavers in the same period. Sickness levels were low at 1% that is below the NHS average of 4.8%.
- Wards were able to maintain safe nurse staffing, despite the hospitals recruitment challenges. Staffing was on the risk register with an action plan.
- On Oxford ward, there was one registered nurse and two health care workers during the day and one registered nurse and one health care worker at night. Cambridge ward had two registered nurses and three health care workers during the day and two registered nurses and two health care assistants at night. Rotas seen confirmed these levels were met.
- For the period June, July and August 2015 on Cambridge ward there was 114 shifts covered by bank staff and nine covered by agency staff. Nine shifts were not covered by bank and agency staff. Supernumerary staff and staff from other wards were used to cover.
- Oxford ward used 29 bank staff shifts and three agency staff over this period. All shifts had been covered. Regular bank and agency staff were employed to provide continuity for patients.
- Ward managers could request adjustments to staffing numbers in response to the need for higher levels of observations or special events such as annual sports days. Staff reported managers had supported requests for additional staffing.
- All staff we spoke with told us there was always at least one experienced member of staff in the ward area.
- There was enough staff to provide one to one sessions with patients. Staff reported occasional postponement of these due to the mood of patients and the effect of this on the ward environment. There were enough staff to carry out physical interventions.
- Escorted leave or ward activities were rarely cancelled because there were too few staff. Staffing levels and any cancelled section 17 leave was a standing item in the daily senior team meeting. The notes of this meeting in August 2015 stated there had been no leave cancellations. The service development and clinical governance meetings monitored staffing and section 17 leave and any cancelled leave.
- Minutes of the three most recent Oxford ward meetings included details of section 17 leave and staffing levels. Staff on Oxford ward told us that no patients had escorted leave; however, the ward could struggle if there was escorted leave especially when patients required an escort to attend college. Four patients we spoke with told us they had not had leave cancelled but occasionally leave was later than planned.
- We spoke with three patients on Oxford ward who told us there were sufficient staff. We spoke with five patients on Cambridge ward. Their opinion was mixed, one patient told us they thought there were enough staff and one patient told us they thought there was insufficient staff. Another patient told us sometimes there were not enough staff.
- There was one consultant who covered both wards. A new consultant was due to start in December. There were no junior doctors. The consultant had agreed to provide interim cover to maintain the continuity of care to patients until the new consultant started. Patients we spoke with viewed the consultant in high regard and wanted continuity of care. We found medical cover was sustainable for four months, but not as a long term position.
- Each consultant in the region was on call for four hospital sites for one week in six. They met the policy target for response to out of hour's calls within one hour.
- All staff we spoke with told us they received mandatory training. We found a high level of compliance for staff completing mandatory training at 92%. However, food hygiene training was low at 34%. Managers stated that from September 2015 this would improve as staff would complete this training on line. Immediate life support was at low at 61%, and this was due to new staff being scheduled to receive training in September 2015.

**Assessing and managing risk to patients and staff**

- We found that Cambridge and Oxford wards had systems in place to maintain security. Entry to Cambridge ward was via a secured air lock entry system. This was because there was a low secure ward on site.
- The reception area displayed a list of contraband items for visitors and patients for all wards. There was a signing in system for staff to obtain keys to the ward and alarms before entering and leaving. A staff member on each shift took responsibility to carry out a list of security checks on each shift and signed for these.

# Long stay/rehabilitation mental health wards for working age adults

Good

- Staff were aware of relational security. Thisis the knowledge, and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care.
- All patients had up to date risk assessments and care plans. On admission the short term risk assessment and treatability tool was completed for each patient. These were updated every three months and following patient incidents. Senior managers checked this during daily meetings for the previous 24 hours.
- The historical clinical risk assessment tool, a tool predicting a patient's probability of violence, was completed for each patient. These were reviewed with each patient and a multidisciplinary team intervention plan was identified.
- A traffic light system was used to help patients and staff rate the level of risk and plan what patients could do. Positive risk taking was very much part of the treatment approach and undertaken by the multidisciplinary team with maximum patient involvement. The Oxford ward manager told us there was a good challenge to being risk adverse in the multidisciplinary team meetings. Unescorted leave was the biggest factor in positive risk taking and the team were patient centred and confident in this.
- Staff agreed a patients' property allowance in collaboration with patients. Each patient's allowance was dependent upon their risk level. The patient experience booklet displayed on ward notice boards gave details of this.
- Healthcare workers told us they looked at risk management plans to enable them to understand the triggers for each patient. They told us patients had goals and it was necessary to assess, manage, and take risks for people to achieve. We saw a folder that contained up to date information for bank and agency staff to see at a glance the patients' risks, both historical and current.
- Some rules had been relaxed in line with the principle of least restriction in comparison to the previous Mental Health Act (MHA) monitoring visit in 2014. For example, patients could use mobile phones and access the internet.
- Both wards had patient representatives on the hospital restrictive practice group which looked at blanket rules, in relation to the Department of Health (DoH) guidance "positive and proactive care; reducing the need for restrictive interventions" 2014 and the MHA Code of Practice.
- The patient alliance group had an agenda item relating to restrictive practice. The regional governance group monitored the evidence provided by the wards that demonstrated restrictive practices were being addressed.
- Oxford and Cambridge wards were for rehabilitation so should have less levels of security in comparison to the low secure ward on site. This was evident on Oxford ward. However, on Cambridge ward we observed and patients told us that plastic cutlery was used. One staff member and one patient told us that there were more restrictions on Cambridge ward than on the low secure ward. We saw individualised risk plans for patients on Cambridge ward who self-harmed that showed the required restrictions were to ensure the patients safety.
- The hospital had a policy for carrying out searches. Staff obtained consent prior to searches. Cambridge ward undertook randomised pat down body searches, cutlery checks, and environmental searches and randomised room searches. On Oxford ward, there had been room searches for six patients in July and two in August. These were in accordance with policies, and commissioning contracts.
- Partnerships in Care policies were available on the intranet and staff discussed these in team meetings and supervision. The observation policy had a dedicated electronic training module all staff had completed. Patient observations occurred in accordance with the observation policy. The clinical team agreed the level of observations for each patient on admission. Bank and agency staff were familiarised with standards and procedures for observation. Cambridge ward had one patient on one to one observations. Senior managers' morning meetings monitored patients that were on close observations.
- The hospital had implemented the DoH guidance "positive and proactive care; reducing the need for restrictive interventions" 2014, which underpinned care plans. A range of interventions to manage violence and aggressive behaviour were used, including mindfulness and positive behaviour support (a framework for delivering a range of evidence-based support to increase quality of life and reduce the occurrence, severity or impact of behaviours that challenge". The hospital also used the RAID model (Reinforce Appropriate Implode Disruptive - a philosophy of care that focuses on positive behaviour and recovery) by the Association of Psychological Therapies.

# Long stay/rehabilitation mental health wards for working age adults

Good

- The hospital tried to reduce restraints by using de-escalation techniques. On Oxford ward this was mostly talking to the patient in a quiet room or bedroom, whilst on Cambridge ward there were two "calming" rooms.
- Despite these interventions, we found Cambridge ward had the highest number of physical interventions. The ward received admissions for women who required intensive support to manage challenging behaviours which included self-harm. The ward manager told us the majority of restraint used followed interventions when patients self-harmed. Verbal de-escalation was sometimes effective but this was dependent upon the patient's stage of recovery.
- From November 2014 to April 2015, Cambridge ward had 96 restraints involving 11 patients. Of these, 10 involved prone restraints, four of which resulted in rapid tranquilisation. The DoH guidance is that prone restraints should not occur. Posters displayed in staff areas showed staff how to safely carry out prone restraint. However, a reduction in the number of prone restraints was required. [LP1]. In comparison Oxford ward had 11 restraints involving four patients, with no prone restraints or rapid tranquilisation.
- An incident report was completed when prone restraint was used and body maps showed how the restraint had been managed. There was a breakdown of the types of physical restraints used. The reporting process allowed for details of restraint and action to be recorded and collated.
- The detailed monthly reports of managing violence and aggression for the two wards for the period 1 April 2015 to 31 July 2015 showed no patients and four staff received had injuries through physical interventions.
- Seclusion was a last resort. When used it was for a short duration and there were systems in place to monitor its use. When patients were secluded, staff immediately informed the medical staff and considered the use of rapid tranquilisation; the doctor completed a face-to-face review. The seclusion register showed that seclusions were concluded as quickly as possible and independent reviews were undertaken.
- Cambridge ward had seven seclusions and two long-term segregations in the period November 2014 to April 2015. The use of seclusion was discussed with patients in community meetings. One patient received long term segregation for approximately eight weeks prior to the inspection. This was reported to the patient's commissioners with a request for additional staffing resources to be able to meet the patient's needs in a least restrictive way.
- Managers reported there had been a distinct learning process to sharpen understanding of seclusion and long-term segregation. Policies received regular reviews. Patients under segregation had detailed individualised plans with separate seclusion documentation. The multidisciplinary team and legal department reviewed the patient's re-integration plan into the ward during individualised care reviews.
- Patients had a choice of being debriefed by their preferred member of staff or another staff member following seclusion. Seclusion records had a built in patient review to enable patients to talk about what had happened.
- The hospital had a suicide prevention policy and participated in the national suicide prevention audit.
- Three patients on Oxford ward and four patients on Cambridge ward told us they felt safe.
- There were clear systems in place to manage and report incidents of safeguarding. Ninety per cent of staff had completed safeguarding training. Staff could describe different forms of possible abuse and how to report it. The social worker took the lead in safeguarding but nursing staff could raise alerts out of hours. The wards used a safeguarding tracker to highlight both concerns and referrals. The daily senior managers' morning meeting, individual case reviews, and multidisciplinary team meetings reviewed safeguarding concerns. Minutes of the regional clinical governance group showed the social worker produced a report and that monitoring took place.
- The hospital had good links with Nottingham multiagency safeguarding hub and made safeguarding alerts and referrals to them. Joint meetings reviewed the safeguarding referrals. The local safeguarding team provided advice and support to the hospital. The social worker kept a log of all safeguarding concerns raised.
- A ward manager told us safeguarding alerts had fallen dramatically over the past two years and said this fall was due to changes in leadership. Staff were now more alert to ward dynamics and worked more collaboratively with the patients. The safeguarding adults report from December 2014 to April 2015 showed 10 alerts were made at Annesley House. The process for maintaining the safety of patients included a number of different

# Long stay/rehabilitation mental health wards for working age adults

Good

review processes to monitor concerns. Managers told us they were confident there were good levels of reporting. We tracked two safeguarding incidents and found they had been managed appropriately.

- On Cambridge ward, two patients told us they had experienced verbal aggression from other patients and one patient told us they had not experienced any aggression. Another patient told us they had previously not felt safe. However, they now had staff they could trust and talk to and this good relationship had helped them feel safe. A safeguarding referral had been made following an incident of bullying between patients. Two of the three patients on Oxford ward told us they had experienced verbal aggression from other patients.
- Community minutes showed discussions about bullying took place. Incidents were referred to safeguarding, resulting in investigations and individual safeguarding plans.
- There was safe administration of medicines on both wards. Controlled medicines were kept in separate locked cupboards and records kept as required. Two registered nurses checked and dispensed these drugs.
- Staff told us there was a lack of clarity around the storage, return, and disposal of unwanted stock medicines. The local pharmacy provided a service to the hospital, and undertook a weekly audit of stock. The ward manager reported there had been some delivery problems with the pharmacy that was under investigation. Medicine storage on the ward had been reviewed and changes made to improve stock control whilst discussions with the pharmacy continued.
- The regional governance meeting monitored management of medicines and the pharmacy contract. A contract review was pending in September 2015 to address concerns and to make improvements.
- A family visiting room was provided, complete with toys off the ward area. The social worker carried out a risk assessment to make certain it was in the best interests of a child to visit.

**Track record on safety**

- Cambridge and Oxford wards had no serious incidents reported from May 2014 to May 2015.

**Reporting incidents and learning from when things go wrong**

- All staff we spoke with were able to explain the types of incidents; reporting processes and what to record. We tracked two incidents and found they had been appropriately managed and were referenced into the patient's notes.
- Systems for disseminating lessons learnt and changes in practice occurred. Learning from incidents took place during ward morning meetings, shift handover, by email, supervision, and reflective practice meetings. Minutes of the service development and clinical governance meetings showed the review of incidents and lessons learnt was a standard agenda item.
- Staff gave examples of lessons learnt and changes in practice in response to coroner's notifications and serious incidents. Changes included supporting transition processes between adolescent and adult services.
- Staff reported they had debriefing sessions following incidents and these were recorded as supervision. Support occurred in a variety of ways, for example, staff members could move to another ward where appropriate. Support from psychology and a help line were available. Patients received debriefing following an incident and staff recorded this in the patient's care notes.

## Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

**Assessment of needs and planning of care**

- The pre-admission report contained the initial needs formulation (a theoretically based explanation of the information obtained from a clinical assessment). 72 hours after admission the care plan was agreed and this included the formulation.
- Patients had their pre-admission needs formulation with expected milestones reviewed with them during individual case reviews and care programme approach (CPA) meetings. Where anticipated milestones were not reached, the possible reasons for this were analysed.

# Long stay/rehabilitation mental health wards for working age adults

Good

- Records showed there was an assessment of physical health needs on patient admission and evidence of ongoing physical health checks.
- The wards used a nationally recognised good practice recovery tool called, "my shared pathway". Thisis part of the national secure services programme. It is about developing a recovery approach to identifying and achieving outcomes and aims to reduce the length of patient stay in secure services. Patients were enabled to contribute to their planning of their recovery, health, relationships, and safety. We saw care plans for life skills, physical health, relationships, safety, and risk insight. Part of the shared pathway booklet identified the patient's perception of their risks. The language in the care plans was a mixture of the patient voice and professional language.
- The visiting GP received the same clinical governance training as hospital staff in order to input into to the hospitals electronic patient records. This meant that information about the patient was readily available to all those involved in their care.

**Best practice in treatment and care**

- National institute for health and care excellence (NICE) guidance was evident in care planning and underpinned working with people with a personality disorder with least use of medicines. Prescribing followed British National Formulary guidelines and the medical staff reported good liaison with the pharmacy.
- Patients had access to a range of therapies and evidence based care. The hospital governance group reported patients had 100% access to psychological therapies in April 2015. Patients had access to clinical psychology and dialectical behaviour therapy (DBT, a specific type of behavioural therapy to help people change patterns of behaviour that are not helpful). Psychologists provided individual and group sessions for patients.
- The Association of Psychological Therapies approved Annesley House as a RAID centre of excellence (Reinforce Appropriate Implode Disruptive - a philosophy of care that focuses on positive behaviour and recovery). All staff received training in RAID and staff spoke positively about this philosophy. Posters were displayed on ward notice boards giving information about RAID. Staff RAID champions helped to promote the approach to other staff members to help make the service a positive place to be.
- Psychologists worked with new patients on admission to complete psychological assessments including clinical outcomes in routine examination, the brief symptom inventory (patient self-reporting inventory), and the personality assessment inventory.
- A physical health care worker and regional registered general nurse provided physical healthcare assessments. There was a contract with the local GP practice who visited weekly. The patient alliance had identified patients who would like access to female GPs. A pilot had been agreed with the surgery and plans for a female GP visit once a month.
- The tools used to measure patient recovery outcomes included health of the nation outcome scales and EuroQol (a standardised instrument for use as a measure of health outcome).
- The occupational therapy service saw patients within three days of admission. The team used standardised assessments such as the model of human occupation screening tool. This addressed patients' motivation for occupation, pattern of occupation, communication/ interaction, process, and motor skills, and environment. Following a baseline assessment, re-assessment occurred every six months to provide a measure of patient progress.
- Staff participated in various audits including a brief audit on the completion of the short-term assessment of risk and treatability tool (START) in 2014. STARTs were being completed as required and were up to date. Both wards had participated in local and national audits. For example; The national audit of schizophrenia (awaiting results), anti-psychotic prescribing with people with learning disabilities, long term management of self-harm (awaiting results), national suicide audit, and an audit looking at the use of sodium valproate.

**Skilled staff to deliver care**

- The multidisciplinary team included the ward manager, responsible clinician, occupational therapist, psychologist, and social worker. There was a psychologist vacancy and recruitment had taken place. In the meantime, the ward received on-going support from the lead psychologist and assistant psychologist. There were three qualified DBT's and an advertisement had recently been placed informing staff of more DBT training opportunities so that more therapists were

available. As part of staff continuing professional development DBT awareness sessions had been offered to all staff so that general principles could be implemented.

- Staff received an appropriate induction. This included a total of two weeks in the classroom, and working as a supernumerary member of staff for one week. Staff completed a folder of learning which managers signed off on successful completion of the probationary period. Health care workers completed the care certificate workbook. Bank and agency staff completed an induction similar to permanent staff.
- Staff were supervised, appraised and had regular access to team meetings. All staff we spoke with told us they received good managerial and clinical supervision usually every four to five weeks. The uptake of managerial and clinical supervision was high at 92%. All staff had appraisals within the last year. Reflective practice sessions occurred on each ward on a three weekly basis.
- Staff had access to funding to attend external courses and university modules. However, two staff on Oxford ward and two staff on Cambridge ward told us they had not received training in specific clinical conditions such as eating disorders, autism, and schizophrenia. A patient and their carer stated there was a lack of skilled staff in working with people with eating problems. Managers said a wide range of distance learning training was available to staff including eating disorders, Asperger's syndrome, and mental health.
- Occupational therapy staff told us they did not feel they understood sensory issues enough to identify and meet the needs of people with autism. Therefore, staff need to receive the necessary specialist training for their role.
- Poor staff performance was addressed promptly and effectively. For example, a patient reported a concern about an agency worker and following investigation the agency staff had not worked on the ward again.

**Multidisciplinary and interagency teamwork**

- There were regular and effective multidisciplinary meetings. There were weekly meetings to plan and review patient care which involved the patient. We attended an individual case review with the permission of the patient. This involved a discussion by the team prior to the patient joining the meeting. The meeting was well structured and all parties had an opportunity to contribute and their views respected. The meeting was centred on the patient who was given time to express themselves and their views were listened to. The team worked in partnership with the patient, was flexible in approach, and looked at ways to meet the patient's particular needs and requests.
- There were effective handovers between each shift. We attended a handover on Cambridge ward which was structured and was recorded. A health care worker told us the handover record was very useful because all information was in one place.
- There were effective working relationships with teams outside of the organisation. A CPA meeting occurred 12 weeks following admission and six monthly thereafter. This included external services and the patient's family with consent of the patient.
- Social workers based at Annesley House maintained links with clinical teams from referring authorities. The frequency of contact varied according to distance from referring authority.

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

- Ninety seven per-cent of staff had received training in the MHA. There was a plan to update training and policies based on the new MHA Code of Practice. There was access to the MHA and Code of Practice through the hospital intranet and hardcopies on each ward.
- All the patients on Oxford and Cambridge wards were detained under the MHA. During this inspection we carried out a specific Mental Health Act monitoring visit on Cambridge ward.
- On both wards all patients had their medication authorised on a treatment form (T2 or T3) which was attached to their medication charts. This meant that staff would know the legal authority under which they were providing medication. Electronic notes recorded capacity assessments and consent given to medication. This was an improvement on our previous MHA monitoring visit in 2014.
- The administration of emergency medication under section 62 was audited. Cambridge ward had the highest number; this was linked to it being an admission ward for women who displayed behaviours that could challenge.
- The responsible clinician authorised section 17 leave on the electronic system. This followed discussion about risk and leave in the individual patient weekly reviews by the multidisciplinary team. The decision to grant section 17 leave was dependent upon the assessment

# Long stay/rehabilitation mental health wards for working age adults

Good

of the patient's mood and any changes to risk identified by the nurse in charge. We found in the seven files we looked at that pre-section 17 leave risk assessments and outcomes of leave forms were not completed. This meant that it was not clear how the nurse in charge had made the clinical judgement that it was safe for the patient to go on leave.

- Contingency plans were used for leave, which contained the conditions of leave, what to do if the patient did not return and the description of the patient. Escorting staff received verbal and written information about risks specific to the patient prior to leave. All staff escorting the patient on leave signed the contingency form.
- Information about patients' rights were given in accordance with section 132 verbally and in writing and a record made. This included information about the independent mental health advocacy service (IMHA). Information about rights was repeated to the patient every three months. Patients signed a hard copy of the rights information. However, there was no record that the patient's capacity to understand their rights was assessed.
- Patients had exercised their rights by accessing mental health tribunals, hospital managers' hearings, and IMHA. Patients had access to legal representation.
- Copies of detention papers were available on electronic care notes so that staff could see what legal authority they were using to treat the patient; however these were not consistently filed.
- An MHA administrator was employed by the hospital. They kept the original detention papers for patients and scanned copies onto the electronic record. They audited the implementation of the MHA and sent clinical staff reminders of key events and timescales that required adherence in accordance with the MHA.
- There was access to legal advice from the organisations legal representatives.

**Good practice in applying the MCA**

- There was good uptake of the Mental Capacity Act (MCA) training with 97% of staff undertaking it. However, staff we spoke with had a variable understanding of the MCA and were generally not able to tell us the five guiding principles of the act. Managers reported electronic learning modules for MCA and deprivation of liberty safeguards would be available to further increase understanding in September 2015.
- Staff had access to the MCA and Code of Practice via the hospital intranet and hard copies on each ward.
- Staff reported patients received support to make decisions and when the patient was assessed as lacking capacity the multidisciplinary team would consider their best interests.
- Advice for staff was available from the Mental Health Act administrator, medical staff and the hospital social workers.
- There were no current deprivation of liberty safeguards applications.

## Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

**Kindness, dignity, respect and support**

- Staff were caring and supportive of patients.
- Three patients we spoke with on Oxford ward and three patients on Cambridge ward were complimentary about staff. They told us staff were respectful and polite, they knocked on doors before entering bedrooms, and were caring and interested in patients' wellbeing. One patient we spoke with on Cambridge ward did not feel staff were respectful.
- The majority of family carers we spoke with were also very positive about the approach of staff stating that patients felt relaxed with them.
- We had very positive feedback about some specific staff on the wards. Patients described staff as being fabulous or fantastic and praised them highly.
- During our inspection, we observed staff interacting positively with patients in a kind and caring way. On Oxford ward, we observed staff engaged with games on the Wii with patients and the ward had a relaxed atmosphere. We saw a dog around the building that patients could walk and play with and two patients showed us their pets. On the day of our inspection, there was a sports day in progress and we saw patients from all wards in a relaxed and informal atmosphere with positive staff interaction.
- We attended a community meeting (patient meeting) on Cambridge ward where patients discussed bullying. Staff had a good rapport with patients and listened to

what they said. Minutes of community meetings included "getting on with each other" as a standard agenda item, this included behaviours classed as bullying. The wards used a range of techniques to manage bullying. Staff told us there was a zero tolerance approach to bullying. They told us some patients just did not get on. Staff tried mediation and training called "living together" had been introduced for patients and staff on the wards. Staff and patients referred to red and green behaviours as either inappropriate or appropriate behaviour when discussing arguments. Staff tried to reinforce green behaviours and used verbal de-escalation. Patients could ask for one to one time with staff following arguments to discuss their concerns.

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

- Patients we spoke with confirmed they had been orientated to the ward and given information about what to expect by nursing staff. All new patients had an identified peer who acted as a "buddy" by welcoming and helping them to settle into the ward. Each patient received an introduction to their primary nurse and met the responsible clinician.
- Patients we spoke with said they felt involved in their assessment, care planning, and reviews. Patients could have copies of their care plans.
- Three patients on Cambridge ward and three patients on Oxford ward told us they felt involved in their care. One patient said they had been actively involved in their discharge plan and had access to advocacy. Another patient said they were given information about treatment and involved in their care planning. They said they wrote their care plans and discharge plan with their primary nurse.
- The advocacy service provided independent mental health advocates. They visited all the wards once a week, and spoke to all of the patients. They attended care programme approach (CPA) meetings and individual case reviews when requested. They told us patients felt involved in developing their care plans and risk management plans. The advocacy service met with senior managers on a quarterly basis to discuss themes. The independent advocacy service report June 2015 was reviewed. It identified 19 different types of issues they had been involved in and noted that issues had been addressed.
- Staff respected patients choices in involving their family in care and the level of carer involvement depended upon the patients consent. One patient on Oxford ward and two patients on Cambridge ward told us very clearly they did not want their family involved in their care. One patient on Oxford ward and one patient on Cambridge ward told us their families were involved in their care because they wanted them to be.
- The social worker managed the approval list for visitors working with patients, relatives, and ward staff. They spoke to the family of the patient, agreed and updated necessary records and care plans. Verbal consent to involve and share information was obtained and recorded in the electronic care notes. Prior to home leave, the social worker completed an environmental risk assessment and established relationships with relatives.
- Four out of six carers on Oxford ward and two out of five carers on Cambridge ward we spoke with would have liked more involvement in the care of their relatives. Five carers said they were involved in their relatives care. Carers received an information booklet, "working in partnership with families, friends, and carers" which included details of visiting and contacting the organisation if there were any concerns.
- Managers told us that a draft carer involvement strategy consultation had taken place at the beginning of August 2015 and some suggestions for change made. They explained other action taken to improve links with families included arranging for a relative to visit the ward to see where their family member was staying by prior arrangement with staff and patients. Open days had been arranged for families to visit but these had not generally been well attended.
- We found there were systems for patients to feedback and to influence service changes. The hospital carried out annual patient surveys to find out patients views. The 2014/15 survey had nine responses across the hospital. It was not possible to break responses down to wards. An action plan was in place.
- We attended the community meeting on Cambridge ward and saw the agenda included flooring and carpets. The meeting agreed they request curtains for the living area. They also discussed the management of patient arguments. We observed good staff rapport with patients, and the ward manager listened to what patients said.

# Long stay/rehabilitation mental health wards for working age adults

Good

- We spoke with patient alliance representatives who told us there was a regional meeting every two months. This included representatives from other units within the Partnerships in Care organisation. They raised patient issues and were involved in projects about service development. The agenda included such topics as restrictive practices, living areas, catering, protocols and policies. The representatives told us they definitely felt listened to.
- The patient alliance reported that patients had requested a new kitchen. Patients were involved in planning this and installation took place within two months of the request. Patients had also requested an increase in the shopping budget and the hospital had provided more than they requested.

## Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

### Access and discharge

- The bed occupancy for the period 1 November 2014 to 31 March 2015 for Oxford ward was 94% and Cambridge ward 86%.
- Beds were readily available to NHS England commissioners to place patients following assessments.
- All new referrals to the ward were brought to the morning meeting where it was agreed which member of the team would undertake the initial assessment. The assessment was completed within five working days. The senior manager's morning meeting reviewed the pre-assessment report and made the decision to accept or refuse the referral. Patient mix and ward dynamics were considered as part of the decision making process. The ward could refuse to admit a person referred if the team felt the referral was not appropriate.
- Discharge was not delayed for other than clinical reasons. Annesley House reported no delayed discharge for the six-month period November 2014 to the end of April 2015.
- Patients followed a clinical pathway within the organisation, going to step down rehabilitation facilities in the Midlands or near their home area following discussion with NHS England specialist commissioners.
- The average length of stay on Oxford and Cambridge wards was two years. Each patient had a predicted date of discharge. Three patients were predicted to be discharged from Oxford ward within 12 months. We saw evidence of discharge planning in notes we reviewed .Two patients on Oxford ward and one patient on Cambridge ward told us they had been involved in planning their discharge.

### The facilities promote recovery, comfort, dignity, and confidentiality

- There were a range of facilities and activities available to promote recovery. Patients on all wards had access to rooms used for therapy, activities, and interviews.
- There were two visitors' rooms and visiting was by appointment.
- Patients could make a phone call in private. There was a mobile phone policy. Patients entered into a personal contract about the use and type of mobile phone following a risk assessment. All patients had access to mobile telephones either their own or those provided by the ward. There was also access to telephones in quiet areas on the ward.
- Patients had access to the well maintained communal garden and smoking garden. Arrangements for smoking were hourly between 8.00am and 8.00pm. Patients on Oxford ward could access the garden throughout the day freely. Patients on Cambridge ward accessed the garden via a locked staircase. There had recently been a review of the protocol for garden access from Cambridge ward as it was felt this was too restrictive. There were plans to increase access so patients with unescorted ground leave could enter and garden without staff.
- The garden had been personalised by patients. There was a 'fairy garden' displaying birdhouses made by patients and some patients had grown their own produce. There was also access to a tennis court and large green space for sports.
- Patients had access to hot drinks and snacks until midnight. On Cambridge ward, patients had access to drinks and snacks during the day. If risk assessed as safe they could have the key to the kitchen, but not at night.

# Long stay/rehabilitation mental health wards for working age adults

Good

- Patients on Cambridge ward could personalise their bedrooms but the degree of personalisation depended on their risk status. If assessed as "red" this meant virtually no personalisation but if assessed as "green" this included most things. Bedroom access during the day depended on the patients risk status. On Oxford ward, patients had personalised their bedrooms and could access these at any time unless there was an assessed risk. However, patients were encouraged to attend structured activities.
- Patients had somewhere secure to store their possessions. Three patients on Oxford ward and four patients on Cambridge ward told us they felt their possessions were safe.
- Each patient was offered over 25 hours of activity a week. The uptake of activities was audited. Patients consistently told us they participated in a range of activities. Each patient had an individualised programme of activities which addressed their therapeutic, social, educational and leisure needs.
- Patients were supported to access vocational roles and real work opportunities as a progression to accessing voluntary/paid roles in the community. Two patients were in community based voluntary work and two were working towards this. There were also work roles within the hospital which included a nail technician and newsletter editor.
- The independence of patients on both wards was promoted by encouraging cooking, budgeting, and unescorted leave.
- Occupational therapists and technical instructors provided a range of activities such as dog walking, a breakfast club, creative writing, drama, fitness sessions, community skills, and a hobbies group. Patients could attend coping skills, problem- solving, anxiety management and a drugs and alcohol group. The therapy timetable was evaluated quarterly with patients' involvement.
- Two full time recovery workers were available five days a week to support all three wards at Annesley House and covered six days out of seven including either Saturday or Sunday.
- Technical staff told us that weekend working to provide activities was not effective because patients were not keen on formal activities at the weekend. There were less technical staff hours during the week if they worked a weekend. In response to this the occupational therapy service had planned to try a new approach on the next programme due to start at the end of September 2015.

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

- Ward notice boards contained up to date information about the Mental Health Act and advocacy, treatments, healthy lifestyles, how to complain and weekly activities. Patients contributed to the information boards and information leaflets.
- Leaflets were not available in other languages however, leaflets in specific languages could be ordered when required.
- We saw an information booklet containing information about the hospital prepared by patients. This included information about RAID. It gave details about what RAID meant (with a clear explanation of both red and green behaviours) and explained each ward had a RAID representative. Other information included details of the patient alliance and the role of the representatives, psychology and occupational therapy services, and ward routines and expectations. Views of patients about their experience at Annesley House were also included.
- Staff respected patients' diversity, religious and cultural needs, and human rights. For example, an Imam had visited at the request of one patient and the wards had links to the church in Annesley which patients attended if they wanted to.

**Listening to and learning from concerns and complaints**

- We found there were systems in place to raise concerns and complaints. During the period May 2014 to May 2015 Cambridge ward had one complaint, which was upheld. Oxford ward had four complaints of which two were upheld.
- Complaints leaflets were available. Patients we spoke with were aware of the complaints procedure. One patient told us they knew how to complain and told us they had made two formal complaints that were "dealt with badly"; but they had now been resolved satisfactorily with staff. We looked at this complaint in detail and discussed it with managers who confirmed this had now been resolved. They told us in future the senior managers' morning meeting would include complaints as an agenda item.

# Long stay/rehabilitation mental health wards for working age adults

Good

- The weekly community meeting also gave the opportunity for patients to raise concerns the ward could action.
- Staff knew how to manage complaints. Staff reported complaints were often resolved at a local level. A ward complaints book recorded complaints made which were reviewed at multidisciplinary team meetings. The ward staff investigated the informal complaints, managers investigated formal complaints. The complaints log on Oxford ward was reviewed daily by staff. Staff had logged two informal complaints and these had been resolved within one day and five days. Records showed complaints linked to the electronic patient records.
- "Concern line" and "talk to us" posters were displayed on the wards. There was a complaints policy and a staff complaints booklet that answered questions staff had about handling complaints.
- Complaints were a standing item on the development and clinical governance meeting. Feedback on learning from complaints occurred through training and reflective practice.

## Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

### Vision and values

- PiC's core values were: quality, integrity, valuing people, caring safely and teamwork. Staff told us the values were on the intranet. All staff we spoke with were clear about their wards vision and purpose.
- All staff spoke about the high visibility of senior managers. Senior managers visited the ward at least once a week. Staff told us the chief executive officer visited once a year. The regional director visited the ward once a month and staff reported they were approachable for both patients and staff.

### Good governance

- We found there were governance structures in place to monitor risk and action plans.
- Minutes of the regional service development and clinical governance meeting showed a range of governance areas reviewed. These included risk management, staffing, education, clinical audit and patient and carer involvement, effectiveness and outcomes.
- Weekly reviews of all ward quality dashboards occurred. These summarised key performance indicators that enabled the wards to see where progress was required and targets achieved. They included care planning, community meeting and patient sessions with their primary nurse, and access to psychological therapies, Mental Health Act status and discharge planning.
- The regional service development and clinical governance meetings reviewed the ward dashboards and any required actions identified. Board governance committees provided an overview of risks and actions plans and gave recommendations and advice. Managers shared lessons learnt with staff.
- Commissioning for quality and innovation (CQUIN) targets, contract performance, and monitoring of service development were monitored by the regional and board committees.

### Leadership, morale and staff engagement

- Staff sickness at Annesley House from February to July 2015 ranged from 3% in February to 1.3% in July. This was lower than the NHS average of 4.8%.
- All staff we spoke with told us there was an open culture and felt confident to whistle blow, raise a grievance or make a complaint. Whistleblowing policies and procedures were available on the company's intranet. A "concern" line telephone number enabled staff to report concerns. Staff also told us they would raise any concerns through their team leader or registered manager. They felt their manager would support them.
- All staff we spoke with told us they experienced good leadership at ward and organisational level. They all received regular support and good access to their manager.
- We heard many positive comments from staff about how they felt about their work and colleagues and that morale was good.
- Staff told us how they felt things had changed and improved. They said morale had been terrible and there was a lack of structure and poor supervision but now the managers were approachable and willing to listen. Staff described working in supportive teams and being able to ask if they were unsure.

# Long stay/rehabilitation mental health wards for working age adults

Good

- Cambridge and Oxford wards had regular team meetings. Review of the minutes of these in July and August 2015 showed items discussed such as complaints, section 17 leave and staffing. Staff who attended meetings out of their working hours were paid, and cover was arranged for staff on duty to attend.
- A range of initiatives were in place to retain staff such as an academy for newly qualified staff, commitment to learning and development, recognition of good practice and staff excellence rewards. Proposed initiatives included payment of the annual nursing and midwifery council registration fee, extension of the notice period for key staff and a strategy regarding supporting revalidation.
- Monthly "meet the director" sessions occurred to enable staff to tell the hospital director what was good and what required improvement. Consequently, all staff had met the hospital director. The director kept notes of the meetings and it was intended to publish staff suggestions for change. We saw posters advising staff how they could feed items directly to the board.
- Some staff were able to tell us duty of candour was being completely open and honest with everybody and apologising when things went wrong. The senior managers' morning meeting reviewed all incidents and discussed if duty of candour should be applied. No incidents had occurred in which it needed to be exercised.

**Commitment to quality improvement and innovation**

- Annesley House has successfully completed the self and peer-review parts of the Quality Network for Forensic Mental Health Services annual review cycle. The report (March 2014) noted that Annesley House met 88% of low secure standards.

# Outstanding practice and areas for improvement

## Outstanding practice

- Durham ward had used the DoH and CQC guidance on promoting the development of therapeutic environments and minimising all forms of restrictive practice to review practice on the ward. The DoH had visited and commended the organisation for what they had done. Key staff received invitations to join the national group established by the DoH.

## Areas for improvement

### Action the provider SHOULD take to improve

- The hospital should continue to reduce the use of prone restraint.
- The hospital should ensure there are clear arrangements for returning unwanted medication to the pharmacy service.
- The hospital should ensure patients risk assessments are recorded prior to section 17 leave.
- The hospital should ensure staff are aware of their responsibilities under the Mental Capacity Act and adhere to the Code of Practice.
- The hospital should ensure patient's capacity to understand their rights is recorded.
- The hospital should ensure required staff complete food hygiene training.
- The hospital should ensure that calming rooms have the facility to reduce light into the room.
- The hospital should continue to ensure staffs have good access to specialist training especially autism and eating disorders. Occupational therapists should have a greater understanding of sensory needs of people living with autism.