St Andrew's Healthcare

St Andrew's Healthcare - Birmingham

Inspection report

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Date of inspection visit: 24 January 2024, 25 January 2024
Date of publication: 10/04/2024

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated St Andrew's Healthcare Birmingham as requires improvement because:

- The service did not always have systems and processes to safely administer, record and store medicines.
- Managers did not ensure that sufficient staff received updated training in basic life support.
- The service had enough staff, but they were not always deployed effectively to support patients on each ward and staff reported feeling burnt out.
- Staff did not always discharge their roles and responsibilities under the Mental Capacity Act 2005 as patients' decisions made about resuscitation were not regularly reviewed and updated where needed. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were not regularly reviewed or updated.
- The service had some blanket restrictions in place on some wards regarding accessing the courtyard and use of vapes. The provider gave an explanation that these restrictions were necessary and proportionate for managing risk. They were frequently under review through governance processes. However, there were not individual patient care plans for these.
- Care plans were generic and did not show the patient was involved. They did not all include discharge plans.
- Patients were not regularly engaged in therapeutic activities.
- The governance processes were not fully embedded to ensure that ward procedures ran smoothly.

However:

- The ward environments were safe, clean and well maintained.
- Staff followed good practice with respect to safeguarding.
- Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured staff received supervision and appraisal.
- The ward staff worked well together as a multidisciplinary team.
- The ward teams had access to the full range of specialists required to meet the needs of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood their individual needs.
- Staff planned patient discharge and liaised with services that would provide aftercare, however not all patients had a discharge plan in their records.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	We rated St Andrew's Healthcare Birmingham as requires improvement because: • The service did not always have systems and processes to safely administer, record and store medicines. • Managers did not ensure that sufficient staff received updated training in basic life support. • The service had enough staff, but they were not always deployed effectively to support patients on each ward and staff reported feeling burnt out. • Staff did not always discharge their roles and responsibilities under the Mental Capacity Act 2005 as patients' decisions made about resuscitation were not regularly reviewed and updated where needed. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were not regularly reviewed or updated. • The service had some blanket restrictions in place on some wards regarding accessing the courtyard and use of vapes. The provider gave an explanation that these restrictions were necessary and proportionate for managing risk. They were frequently under review through governance processes. However, there were not individual patient care plans for these. • Care plans were generic and did not show the patient was involved. They did not all include discharge plans. • Patients were not regularly engaged in therapeutic activities. • The governance processes were not fully embedded to ensure that ward procedures ran smoothly. However:

Summary of findings

- The ward environments were safe, clean and well maintained.
- Staff followed good practice with respect to safeguarding.
- Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured staff received supervision and appraisal.
- The ward teams had access to the full range of specialists required to meet the needs of patients.
- The ward staff worked well together as a multidisciplinary team.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood their individual needs.
- Staff planned patient discharge and liaised with services that would provide aftercare, however not all patients had a discharge plan in their records.

Summary of findings

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Summary of this inspection

Background to St Andrew's Healthcare - Birmingham

St Andrew's Healthcare is a registered charity. St Andrews Healthcare Birmingham is an independent hospital which provides medium and low secure support for people with mental health needs. The hospital is registered to accommodate up to 126 people and is made up of eight wards: Edgbaston ward is a 15 bed medium secure ward for men with mental health needs;

Hawksley is a 15 bed medium secure ward for men with mental health needs;

Hazelwell is a 16 bed low secure ward for men with mental health needs;

Hurst is a 16 bed low secure ward for men with mental health needs;

Lifford is a 16 bed low secure ward for older men with mental health needs;

Northfield is a 16 bed low secure ward for men with mental health needs;

Moor Green is a 16 bed low secure ward for women with mental health needs;

Speedwell is a 16 bed low secure ward for men.

The CQC registered St Andrew's Healthcare Birmingham to carry out the following regulated services/ activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Treatment of disease, disorder or injury.

The hospital has been inspected four times since registration in 2011. The last inspection was carried out on 26, 27, 28 June 2018 when the hospital was rated as Good overall, Safe as requires improvement, Effective, Caring and Well led as Good and Responsive as outstanding.

What people who use the service say:

Patients described staff as polite, good, kind and do their best to help.

Patients said they sometimes don't have the food that meets their cultural needs, another patient said they did.

Patients said if they were unwell, they always saw a doctor quickly.

Patients described the wards as noisy at times, however they felt safe and said when there were incidents staff intervened quickly.

Patients said they knew how to make a complaint, but two patients said when they had complained they did not get a response.

Patients said they had access to advocacy services. They said they could access their own mobile phones to use in their bedrooms so they could keep in touch with family and friends.

Summary of this inspection

Patients said that sometimes their escorted authorised leave was cancelled or rescheduled due to staffing.

Patients said they could attend their ward rounds although some patients said that staff didn't help them to prepare for these. They said their family were invited to attend if they chose them to be.

2 patients said they could not access the multi faith rooms in the hospital or their places of worship in the community, 1 patient said that chaplains don't visit the ward. However, the provider did provide evidence that the Chaplains visited patients on all wards and that the multi faith room is available upon request.

Some patients said that maintenance issues can take time to resolve, however 1 patient said when their sink was blocked it was fixed quickly, another patient said maintenance issues were done when they asked.

Patients said there were no planned activities at the weekends. They said the gym was small and gym sessions were limited. However, they were encouraged to use the community gym when they had authorised leave. They said they had cooking groups when they shopped for and cooked food.

Patients said the hospital was clean and their rooms were cleaned every day.

How we carried out this inspection

The team that inspected St Andrews Birmingham consisted of an expert by experience (person who has experience of using mental health services), 2 CQC inspectors on site and 1 CQC who conducted interviews remotely, 2 CQC senior specialists in mental health and 1 CQC pharmacist inspector.

We visited unannounced on 24th January 2024 and looked at all five key questions: Safe, Effective, Caring, Responsive and Well Led.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited 5 of the wards: Hurst, Hawkesley, Lifford, Northfield and Moor Green and looked at the quality of the ward environment and observed how staff were caring for patients.
- spoke with 16 patients who were using the service and reviewed patient community meeting minutes on the 5 wards we visited.
- spoke with the service manager and managers for each of the 5 wards.
  - Spoke with the Clinical Director, pharmacist, 1 Quality Matron and an Associate Director of Nursing.
  - spoke with 21 other staff members; including doctors, nurses, occupational therapists, psychologists, healthcare assistants, security staff and social workers.
  - spoke with 1 carer of a patient who used the service.
  - looked at 25 care and treatment records of patients.
  - carried out a specific check of the medicines management on Hurst and Hawkesley wards.

Summary of this inspection

- looked at a range of policies, procedures and other documents relating to the running of the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

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

Is the service safe?

Requires Improvement

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Managers completed regular environmental risk assessments for all wards. However, on Hurst ward the courtyard area was downstairs. Staff said there should be 2 staff when patients were using the courtyard, but this did not always happen due to staffing levels. There had been a recent incident where 1 patient had assaulted another in the courtyard, staff said other staff responded when they pulled their alarm, but they sometimes felt vulnerable alone in the courtyard. We reviewed the courtyard risk assessment for Hurst ward dated 5/1/24. This did not mention how many staff should be there when patients were using the courtyard. It assessed the use of the stairs and how staff were to ensure that patients were safe and that contraband items were not thrown over the walls. The risk assessment was not thorough and did not identify the number of staffing needed which staff had raised as a risk.

Staff were able to observe patients in all parts of the wards. The layout of all wards allowed staff to observe all areas inside the building. The provider told us that managers had also submitted a business case for the review and enhancement of closed circuit television cameras (CCTV) across the site.

The ward complied with guidance and there was no mixed sex accommodation. Wards complied with guidance on same-sex accommodation because all wards were single-sex. There was only one women's ward at St Andrew's Birmingham this was Moor Green ward. However, at the time of inspection there were two female patients on Moor Green ward that required seclusion. This meant that one patient had to use the seclusion room on Hurst (male) ward. Staff from Moor Green ward provided observation for the patient and the doctor and nurses from Hurst ward completed the medical and nursing reviews as required. Throughout the inspection we observed discussions that showed that staff were understanding of the issues and ensured the patients safety, privacy and dignity.

Requires Improvement

Forensic inpatient or secure wards

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers completed ligature assessments, had identified all ligature risks and mitigated against these through observation procedures. Staff knew where ligature assessments and ligature cutters were located on the wards.

Staff had easy access to alarms and patients had easy access to nurse call systems. Patients said they had access to call bells and felt safer to have these. They said that staff responded when they needed to use their call bell.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. The wards we visited were visibly clean. Patients said the wards were clean and their bedrooms were cleaned daily apart from at weekends.

Patient community meeting minutes showed that maintenance issues were discussed at each meeting. A log was kept of action taken and any outstanding issues were discussed at the meeting the following week.

Staff made sure cleaning records were up-to-date and the premises were clean. Records seen confirmed this.

Staff followed infection control policy, including handwashing. We observed antibacterial dispensers around the hospital and staff used these as necessary.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

There were three seclusion rooms in the hospital. The seclusion room on Moor Green ward had access to an extra care area where the patient when assessed as safe to do so could access the shower room there. The other two seclusion rooms had access to a toilet. From all rooms the clock was visible and at the time of inspection was showing the right time. The seclusion rooms met the Mental Health Act (1983) Code of Practice.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic rooms we saw on Hawkesley and Hurst wards were clean and well organised. All medicine drawers and trolleys were locked. The fridge in Hurst ward was found to be unlocked when checked but was locked once staff were made aware.

Staff checked, maintained, and cleaned equipment. Medicines and clinical waste were disposed of appropriately with access to medicine waste bins.

Safe staffing

The service had enough nursing and medical staff, who knew the patients, however they were not always deployed effectively to support patients on each ward. Staff did not all receive basic training to keep people safe from avoidable harm.

Nursing staff

Requires Improvement

Forensic inpatient or secure wards

The service had enough nursing and support staff to keep patients safe. However, staff raised concerns that they did not always get their breaks. They said and we observed that registered nurses were moved to cover other wards which meant that the ward they worked on was left short for that period. Registered nurses raised concerns that newly recruited registered nurses waited sometimes months to be signed off to administer medicines to patients. This meant that other registered nurses had to go to other wards to cover the medicine rounds. However, the provider gave us evidence that 2 of the 3 newly appointed nurses completed this within one month.

The provider had recently assessed the staffing levels at the hospital using the Mental Health Optimal Staffing tool (MHOST). From this they have developed a clinically informed staffing dashboard which was put in use at the time of our inspection. One of the aims of this was to keep occupational therapy and psychology staff separate to the nursing rota so they had time to support patients in meaningful activities and therapies.

The service had reducing vacancy rates. The provider told us that at time of inspection across the hospital there was one deputy ward manager vacancy on Northfield ward, 7.8 whole time equivalent staff nurse and 5.1 whole time equivalent health care assistants' vacancies. These were highest on Hawkesley ward at 4.8 staff nurse vacancies and 3.6 health care assistants on Hazelwell ward.

The service had reducing rates of bank and agency nurses and healthcare assistants. The provider told us that in January 2024 bank staff covered 19% of shifts across the wards and agency staff covered 4.7% of shifts. This had reduced from November 2023 when bank staff covered 21% of shifts and agency staff covered 6.4% and December 2023 when bank staff covering 21% of shifts and agency staff covering 7% of shifts.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff and patients said that bank and agency staff usually worked regularly on the wards so got to know the patients and other staff. However, some staff said that now staffing was managed centrally at the provider's head office in Northampton there were some bank or agency staff who were unfamiliar with the wards.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff spoken with said they had a full induction before they started working at the hospital.

The service had reducing turnover rates. The provider told us that the voluntary staff turnover rate over the last 12 months was 10%.

Managers supported staff who needed time off for ill health. Levels of sickness were reducing. The provider told us that sickness levels had reduced to 5% in January 2024 compared to 9% in December 2023.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The system to calculate the number of nurses and healthcare assistants for each shift had changed at the beginning of the week of our inspection. This was now managed centrally at the provider's hospital in Northampton. Staff raised concerns that those reviewing the staff needed may not be familiar with the hospital in Birmingham and the needs of the patients there. We observed that staff did not have time to engage patients in meaningful therapeutic activities and registered nurses were moved around wards to support administering medicines where staff had not received appropriate training to do so.

The ward manager could adjust staffing levels according to the needs of the patients. Ward managers rotated to the role of site coordinator for each shift. The site coordinator was responsible for ensuring that the right skill mix of staff were on each ward to meet patient needs and observation levels.

Requires Improvement

Forensic inpatient or secure wards

Patients had regular one to one sessions with their named nurse. Patients told us and records showed that they had regular sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. However, patients told us they sometimes had their escorted leave rescheduled to another time due to staffing levels.

The service had enough staff on each shift to carry out any physical interventions safely. Staff told us that if they needed to use physical intervention staff from other wards would assist.

Staff shared key information to keep patients safe when handing over their care to others. There were handover meetings at the beginning of each shift which all staff attended and notes of these were kept for staff to refer to during the shift.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover. The provider told us that across the hospital at time of inspection there were no medical staff vacancies. Patients told us they always saw a doctor when needed.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training, however, not all staff had received training in basic life support. The provider told us at time of inspection that across the hospital compliance with mandatory training overall ranged from 84% to 94%. The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included equality and diversity, human rights, self-harm and suicide, safeguarding, basic and immediate life support, food hygiene, fire safety, health and safety, use of restrictive interventions, record keeping. It also included the Oliver McGowan training in learning disability and autism.

However, although the overall mandatory training figures were high, training in basic life support was below 75% on some wards. For basic life support only 46% of staff on Northfield ward, 55% of staff on Hazelwell ward, 63% of staff on Hawkesley ward, 69% of staff on Speedwell ward and 73% of staff on Hurst ward at time of inspection had received this training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us that managers alerted them when their training needed updating and they also received an email about this.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Requires Improvement

Forensic inpatient or secure wards

Staff completed risk assessments for each patient on admission, using a recognised tool, but did not always review these regularly, including after any incident. Records showed that each patient had a historical, clinical and risk management (HCR- 20). These showed information about the patient, their current and historical risks and how staff were to manage these. However, staff did not always review these after incidents. Three records we reviewed showed that incidents had occurred, but the patients' risk assessments had not been reviewed and updated where needed.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff spoken with were aware of patients' individual risks and how to manage these.

Staff identified but did not always respond to any changes in risks to, or posed by, patients. Three records did not show that staff updated patients risk assessments where needed so all staff were aware of how to manage risks for individuals.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff assessed risks of each patient and increased observations where needed to reduce risks.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Following incidents of patients bringing illicit substances into the hospital the provider had reviewed their search procedures and implemented changes.

Use of restrictive interventions

Levels of restrictive interventions were low. The provider gave us data which showed levels of restraint used were proportionate to the risk posed by the patient and each restraint incident was investigated.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider told us that as of 31 December 2023 81% of staff had received training in least restrictive practice.

Care plans were not in place for restrictions placed on patients such as vaping and access to the garden. However, on Moor Green ward there was a wall around the garden. This meant that patients had access to the garden and to their vapes except at mealtimes to ensure their dietary needs were met. This helped to reduce the restrictions placed on them.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. However, the provider told us that as of 31 December 2023 on 5 wards less than 75% of staff had received updated training in safer interventions. This was as low as 45% of staff on Northfield ward, 52% on Hurst ward, 61% on Speedwell ward, 70% on Hazelwell ward and 71% on Edgbaston ward.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff spoken with had a good understanding of when restraint should be used and ensured this was proportionate to the risk.

Staff followed NICE guidance when using rapid tranquilisation. Records showed that staff rarely used rapid tranquilisation and where needed, assessed the patients' physical health observations. However, a medicine needed to reverse the effects of rapid tranquilisation if needed was not stocked on Hurst and Hawkesley wards.

Requires Improvement

Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. However, on the first day of inspection we saw a patient did not have a care plan for seclusion. We raised this with staff and a care plan was put in place. The care plan helps the patient and staff understand why they are in seclusion, how staff are to care for the person during seclusion and what they need to do to exit seclusion. The provider told us that at time of inspection over 85% of staff had received training in seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There were no patients in long term segregation at the time of inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff were kept up-to-date with their safeguarding training. The provider told us at time of inspection that over 85% of staff had completed training in safeguarding levels 1 and 2 and level 3 for eligible staff. On some wards 100% of staff had received this training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw in patients' community meeting minutes that staff had referred incidents to the local safeguarding team to ensure all patients were protected from harassment by others.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff spoken with knew how to recognise abuse and what to do if they identified a patient was at risk of harm.

Staff followed clear procedures to keep children visiting the ward safe. Children visiting the hospital used a visitor's room in reception.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to make a safeguarding referral and said they would do this following the provider's and local authority procedures.

Staff access to essential information

Staff had easy access to clinical information, however care plans were not always high quality.

Patient notes were comprehensive, and all staff could access them easily. Patients risk assessments were comprehensive however there was limited information in patients' care plans.

Records were stored securely. Most patient records were electronic, and password protected. Positive behaviour support plans were kept in a folder in the ward office which only staff had access to.

Medicines management

The service did not always follow systems and processes to safely administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patients' mental and physical health.

Requires Improvement

Forensic inpatient or secure wards

Staff did not always follow systems and processes to prescribe and administer medicines safely. The service had policies and procedures to support staff to prescribe and administer medicines safely. However, this was not followed with controlled drugs (CDs).

Staff used an electronic system to record the administration of medicine. Another electronic system recorded GP consultations and physical health checks. The patient electronic record system recorded patients' details such as consent to treatment, personal plans, and daily care notes. There was limited interface between all 3 systems. For example, physical health checks recorded in one system was not available in another. This meant where a patient missed or refused a dose of medicine nurses needed to record this information into the patients' electronic record system.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Doctors reviewed patients' medicines weekly in each ward. If a change needed to be made sooner nurses said they contacted the doctor for advice, for example, prescribing a when required medicine regularly. However, if a patient was refusing medicines, for example, a laxative to stop a side effect of a medicine called clozapine, staff told us they verbally told the doctor. However, there was no clear audit trail of this. The doctors relied on ward staff to inform them and did not routinely check missed doses of medicines. Staff assumed another staff member took the responsibility to pick this up however, when different clinicians were questioned it was evident that there was no clear process.

The physical health team carried out electrocardiograms (ECG) to make sure heart monitoring had been done for patients on medicines that required this to be safely prescribed. The team also carried out blood tests for medicines requiring blood monitoring, for example, clozapine, with the results being processed by the hospital. Smoking and caffeine levels were monitored in these patients during physical checks.

The pharmacy team checked high-dose antipsychotic medicines monthly to assess clinical safety. Multidisciplinary team meetings were attended by the pharmacy team on a case-by-case basis due to capacity. However, nurses told us they would like more pharmacy input. The pharmacist worked 3 days a week, alongside a full-time pharmacy technician. The pharmacy team did not attend the ward rounds due to workload and capacity, but nurses felt more support from the team would be useful in the management of medicines.

Medicines not available on the ward but needed out of hours, were accessible from an on-site pharmacy. Patients' medicines were posted out by the provider's pharmacy in Northampton weekly but if a medicine was missing it was posted out by Northampton the following day. Staff assured us this was a rare occurrence, and patients did not go without medicines.

Staff did not always complete medicines records accurately and keep them up to date. Staff were not following the provider's policy to ensure they logged out of the electronic medicines administration record when leaving a computer. We observed staff administering medicines under a different staff member's log-in, this meant records were not accurate.

Mental Health Act consent to treatment documents were in a folder in the clinic rooms. The documents were scanned into each patient's electronic record. The documents were correctly completed with medicines matching those prescribed on the electronic medicine record system. However, on Hawkesley ward, staff did not store prescribing documents safely. The paper versions of consent to treatment documents that provide the legal authorisation for the administration of certain medicines were incomplete and sometimes kept under the wrong patient's name. The folder containing the paper copies was not organised, with pages of the documents missing. One patient who had moved to

another ward a week before our inspection still had his consent to treatment documents in the folder. Some documents were duplicated for the same patient. A new patient to the ward had his documents loose in the folder and not filed. If the electronic patient record was unavailable for a nurse and paper records were being used it would mean the information required for the patient's care and treatment would not be readily available to staff.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Rapid Tranquilisation (RT) was observed to be rarely used and only as a last resort which displayed effective use of verbal de-escalation. Nurses were aware of the post-monitoring required after Rapid Tranquilisation. There were processes in place to ensure patients were kept safe when these medicines were used.

Staff did not always complete medicines records accurately and keep them up to date. Controlled drugs (CD) registers required 2 signatures by 2 nurses when a medicine was removed from the CD cupboard to be given to a patient. However, on Hurst ward, we saw 8 occasions where the CD given was not double-checked by another nurse in the CD register. This concern was raised on the day with the ward manager. We saw for the morning medicine administration the nurse who was logged into the electronic medicine record had to attend another ward. The other nurse administrating the medicines did not log in on their account. This meant there was not an accurate audit trail of who had administered medicines to the patients.

Staff did not always store and manage medicines safely. Staff recorded fridge and room temperatures daily. Medicines and controlled drugs were stored securely and safely. However, in both wards, we found patient-labelled medicine mixed into the overflow stock of medicines. On Hurst ward oxygen cylinders were not stored appropriately as they were not secured correctly.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. On admission patients were given a copy of their electronic medicine record and a letter from the doctor.

Staff learned from safety alerts and incidents to improve practice. Safety alerts were emailed by the pharmacy team and shared with wards and staff had to confirm they had read the alert.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff monitored the effect of patients' medicines on them with regular blood monitoring and physical health checks being completed when needed.

Track record on safety

Safety data provided showed that the service has a good track record on safety. The local coroner had recently issued Prevention of Future Deaths reports to the provider, and we saw that the provider was addressing these issues.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Requires Improvement

Forensic inpatient or secure wards

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff spoken with knew what incidents to report and how to report them on the electronic system.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff spoken with understood the duty of candour and how this was specific to their role.

Managers debriefed and supported staff after any serious incident. Staff told us they had debriefs following incidents and patients also had these.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback following incidents and this included the whole of the organisation not just the hospital at Birmingham.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us they met as a group to discuss feedback from incidents.

There was evidence that changes had been made as a result of feedback. We found that action was taken following coroner's concerns and action was continuing to improve the security arrangements and reduce the risks of patients using illicit substances.

Is the service effective?

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. However, they did not develop individual care plans. Care plans were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs but were not always personalised. Care plans included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Records showed that staff assessed patients' needs on admission which included information from their previous placement where appropriate.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Most patients said their physical health needs were assessed regularly and they saw a doctor quickly when needed. The advanced nurse practitioner employed at the hospital saw patients to assess and monitor their physical health needs.

Staff did not always develop a comprehensive care plan for each patient that met their mental health needs. Most care plans were similar to other patients care plans and often generic. However, care plans related to patients' physical health needs showed these were specific to the patient and their needs.

Staff regularly reviewed and updated care plans when patients' needs changed. Records showed that care plans were reviewed by the multidisciplinary team in patients review meetings and updated when a patient's needs changed.

Care plans were not always personalised. Positive behaviour support plans did not show that the person was fully involved in these but were written in clinical language. Care plans were generic and did not show involvement of the patient.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Records showed and patients told us they were involved in treatment programmes where appropriate that were linked to their offence.

Staff identified patients' physical health needs and recorded them in their care plans. Records showed that patients had a physical health passport which included all their physical health needs and ongoing assessments of their needs. Staff assessed patients at risk of constipation and monitored their bowel habits where needed.

Staff made sure patients had access to physical health care, including specialists as required. Records included pressure area assessments and staff had received training in the Waterlow tool to assess this. Staff assessed patients at risk of falls and developed risk assessments where needed to reduce these.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients' records showed that staff assessed patients' nutritional needs and referred patients to dieticians where needed. Staff assessed patients who were at risk of choking and referred to speech and language therapist where needed. Records showed that staff followed advice from the speech and language therapists.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Records showed that staff supported patients to increase their exercise, have a healthy diet and offered support with smoking cessation. Staff assessed and monitored patients body mass index scores and where needed involved dieticians in their care.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff had training in Health of the Nation outcome scores (used to measure mental health in relation to behaviour, symptoms, impairment and social functioning) and records showed they used these. Records showed that staff assessed patients' physical health needs using the National Early Warning Scores (NEWS) tool. These were reviewed regularly and escalated to doctors where needed.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff told us about quality improvement projects they were involved in. These included reducing observation levels and improving daily summaries in patients care records.

Managers used results from audits to make improvements. Managers discussed audits at clinical governance meetings on each ward and developed action plans to ensure improvements were made.

Requires Improvement

Forensic inpatient or secure wards

Skilled staff to deliver care

The ward teams included most of the specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to specialists to meet the needs of the patients on the ward. However, the provider told us at time of inspection that across the hospital there was 1.7 whole time equivalent psychologist vacancies, 2 whole time equivalent social worker vacancies and 3.1 whole time equivalent occupational therapist vacancies. Patients and staff told us these affected assessments by occupational therapists to enable the patient to move on to further placements.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff said they had access to specialist training when needed.

Managers gave each new member of staff a full induction to the service before they started work. This included bank staff.

Managers supported most staff through regular, constructive appraisals of their work. The provider told us that appraisal rates for most wards were between 81 to 100%. However, they said the appraisal rate for Moor Green ward was at 11%.

Managers supported staff through regular, constructive clinical supervision of their work. The provider told us that at the time of inspection 96% of staff had received clinical supervision. The provider told us that at end of November 2023, 92% of staff had received management supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff told us they attended regular team meetings on the wards and if they could not attend, they could read the minutes of these.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff said they discussed their training needs in supervision and managers supported this although sometimes it was difficult to get the time to do.

Managers made sure staff received any specialist training for their role. Staff told us they could access specialist training appropriate to their role.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Patients told us and we observed that each patient had a regular multidisciplinary team meeting which they were involved in to discuss their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff said there were handover meetings at the beginning of each shift and records were kept of these.

Ward teams did not always have effective working relationships with other teams in the organisation. Staff told us that decisions were often made about the hospital at Birmingham by managers in Northampton. They said this meant they lacked understanding about the needs of the patients and staff there which affected how the hospital was run.

Ward teams had effective working relationships with external teams and organisations. We saw in patient records that patient's care coordinators were invited to their review meetings. Social workers at the hospital liaised with local authority social work teams where needed.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff received combined training in the Mental Health Act, Mental Capacity act and Deprivation of Liberty Safeguards. The provider told us at time of inspection that compliance with this ranged from 80 to 100% across the wards.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff said this was available on the provider's intranet and paper copies were on the ward.

Staff knew who their Mental Health Act administrators were and when to ask them for support. However, some staff said as the MHA administrators were based in Northampton, they did not have direct contact with them face to face and did not always feel they were easy to access.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Patients told us they had access to advocates, and we saw contact details of the advocate were displayed on the wards.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Records showed that staff explained their rights to the patient and repeated these if they did not understand.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and where appropriate with the Ministry of Justice. Records showed and patients told us they had their Section 17 leave as agreed. Some patients said this may be postponed to later in the day or the next day due to staffing levels, but it was not cancelled.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Records showed that SOADs were requested when needed.

Staff did not always store copies of patients' detention papers and associated records correctly. We found on Hawkesley ward that the paper versions of Mental Health Act consent to treatment documents were incomplete and sometimes kept under the wrong patients' name. The folder containing the paper copies was not organised, with pages of the documents missing. One patient who had moved to another ward a week before our inspection still had his consent to treatment documents in the folder. Some documents were duplicated for the same patient. A new patient to the ward had his documents loose in the folder and not filed. If the electronic patient record was unavailable for a nurse and paper records were being used it would mean the information required would not be readily available.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Managers showed us that audits were held and where needed, findings of these were discussed with staff to make improvements.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. However, decisions made about "do not attempt cardiopulmonary resuscitation" were not always reviewed and updated where necessary.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff received combined training in the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. The provider told us at time of inspection that compliance with this ranged from 80 to 100% across the wards.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff said this was available on the provider's intranet.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed that staff supported people with information to make decisions for themselves in a way the person could understand.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Records showed that staff had assessed and recorded the person's capacity to make specific decisions. However, on Lifford ward we saw that on the office board with patient details that some patients had the status of "do not attempt cardiopulmonary resuscitation" (DNACPR). The ward manager told us that these may be out of date and these decisions were made during the COVID-19 pandemic. We asked the provider to ensure these were reviewed with the patient and their advocates where needed. The provider assured us a full review of all patients DNACPRs was completed following our inspection for all patients on Lifford ward. All patients have a resuscitation care plan in place which had been reviewed in the last 4 months with evidence of patient (and/or representative/family) engagement. All plans had a clear review date recorded. They said this information had been updated on the ward board on Lifford where needed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patients' wishes, feelings, culture and history. We saw that where needed best interests' meetings were held where a patient was assessed as not having capacity to make a decision for themselves.

Requires Improvement

Forensic inpatient or secure wards

Staff did not always audit how they applied the Mental Capacity Act but following this inspection managers put in place an audit plan to do this. We asked the provider for further information about how they had audited use of the Mental Capacity Act in particular the DNACPR process. The provider told us that an audit plan was being developed at the hospital led by the quality matron. This would ensure that all DNACPRs are in place and reviewed yearly or sooner if needed.

Is the service caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Patients told us that staff were helpful, kind and good to them. However, we observed that the new security arrangements did not allow privacy and dignity. There was a table in the middle of the hospital reception area where people and their belongings were searched by the security staff using a wand. The provider had submitted a business case for funding to create two rooms to offer privacy and dignity.

Staff gave patients help, emotional support and advice when they needed it. Patients said staff spent time talking with them when needed. We observed staff spending time talking with and listening to patients.

Staff supported patients to understand and manage their own care treatment or condition. Records showed and patients said that staff supported them to understand their needs and how to develop coping strategies.

Staff directed patients to other services and supported them to access those services if they needed help. Staff made sure patients had access to advocacy, solicitors and local housing services where needed.

Patients said staff treated them well and behaved kindly. We observed that staff spoke with patients in a kind and respectful way. We observed that staff listened to people and helped them to develop ways of coping with their distress.

Staff understood and respected the individual needs of each patient. Staff knew patients' needs and what support each person needed to meet their needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff spoken with said they knew how to raise concerns and would be confident to do so if needed.

Staff followed policy to keep patient information confidential. Staff made sure that if they were logged into a computer that they logged out before leaving. Staff did not share information about patients on the ward or in front of other patients or visitors.

Involvement in care

Requires Improvement

Forensic inpatient or secure wards

Staff involved patients in care planning and risk assessment, but this was not always recorded. Staff actively sought patients feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us they were shown around the ward on admission and there was an induction pack for patients. Staff said that if patients were not familiar with the local area, they escorted them on leave to help them know about local services and facilities.

Staff did not always show that they had involved patients in their care planning and risk assessments. This was demonstrated in the records we reviewed which did not always show involvement of the patient. However, patients said they were involved in their care planning and risk assessments. We observed that patients were involved in their reviews by the multidisciplinary team.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Patients said that staff had spent time with them in their multidisciplinary review meeting to discuss their care and treatment in a way they understood.

Staff involved patients in decisions about the service, when appropriate. Patients attended community meetings on the ward and told us they were involved in decisions made.

Patients could give feedback on the service and their treatment and staff supported them to do this. There were regular community meetings on each ward, minutes of these showed patients were involved and we observed this. The ward manager on Moor Green ward was developing a video on women's services for staff training and were involving patients in this.

Staff made sure patients could access advocacy services. Patients were aware of how to contact an advocate. Information about advocacy services was displayed on the wards. Patients said they could invite their advocate to their review meeting if they wanted to.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Patients said that their relatives were involved if they wanted them to be. Relatives told us that staff involved them and kept them updated on their relatives' care. Patients said their family members were invited to their reviews if they wanted them to attend.

Staff gave carers information on how to find the carer’s assessment. Social workers were employed at the hospital and supported carers with information.

Requires Improvement

Forensic inpatient or secure wards

Is the service responsive?

Requires Improvement

Access and discharge

Staff planned and managed patient discharge but did not always show the involvement of the patient in this. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. There was a weekly discharge planning group to discuss who was ready to be discharged and what barriers there may be to this so action could be taken to address.

The service had low out-of-area placements. Managers told us that some patients had recently moved back to the hospital from out of area placements. The provider had recognised the importance of this and was working to bring patients back to the area so they could develop links with their community as part of their rehabilitation.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. We observed a patient had gone on overnight leave to their new placement and their bed was available for them to return to.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. We saw that patients were moved between wards where there had been an incident and to safeguard other patients. They were not moved unless there was a clinical reason.

Staff did not move or discharge patients at night or very early in the morning. Patients were discharged as part of a plan, so this did not happen at night.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Managers held weekly discharge planning meetings and weekly bed management meetings.

Patients did not have to stay in hospital when they were well enough to leave. Patients discharge plans were discussed at weekly meetings and in the patient's multidisciplinary ward round meeting.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well but the plan and patients' input was not always recorded. Patients had a discharge plan, but these were not always personalised and did not include reference to where the patient was to be discharged to. Patients care managers and coordinators were invited to their review meetings either by video call or in person.

Staff supported patients when they were referred or transferred between services. Where possible patients visited before admission to the hospital. Patients were supported to visit their new placements and spend time there.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. However, there was a lack of meaningful activities.

Each patient had their own bedroom, which they could personalise. Patients said they were able to bring in items to make their room personalised if this was not a risk to them or was an item that was contraband. Patients knew what items were not allowed on the ward due to risks.

Patients had a secure place to store personal possessions. Patients had some storage space in their rooms or in other rooms on the ward if needed.

The service had a full range of rooms and equipment to support treatment and care. However, on Moor Green ward we saw that some of these rooms were used for storage of a patients' mobility aids. Patients were not able to access the rooms without staff due to individual risk.

We observed that patients were not actively engaged in activities during our inspection and records showed that activities were often cancelled. In one patient's records from Hurst ward in the week before our inspection 4 activities planned had been cancelled. One patient on Moor Green ward said they would benefit from using a sensory room. The ward manager said this had been raised and they had submitted a business case to the commissioners for funding. They said that the occupational therapists were sourcing sensory items to use in the interim. However, patient records showed that these sessions had been cancelled as orders for sensory items had not arrived. Occupational therapy staff said orders had to be approved by the provider's head office in Northampton so had been delayed.

Some patients said the gym sessions were limited which meant they did not get as much exercise as they would like to. However, patients said that when they had authorised leave, they were encouraged to use gyms in the community. On Hurst ward one of the rooms was being made into a gym, this included a mural on the wall of coastal scenery which the patients had chosen.

The service had quiet areas and a room where patients could meet with visitors in private. Patients said there was a designated room where they could meet their visitors.

Patients could make phone calls in private. Patients were risk assessed for their own mobile phones use. Patients said they could use their mobile phones in their bedroom. On each ward there was also a payphone booth so patients could make calls in private.

The service had an outside space that patients could access easily. On Moor Green ward the garden area had a wall around. This meant that patients always had access to the garden and could vape when they wanted apart from at mealtimes which were protected. This was to support patients to eat regularly and spend time with others at mealtimes. On other wards patients had access to the outside space at specific times so that staff could support. For example, on Hurst ward the courtyard was down a flight of stairs from the ward so staff always needed to support patients there.

Patients on some wards could make their own hot drinks and snacks but on Moor Green ward patients needed staff support to do this. Patients said they would like more cooking sessions with the occupational therapist.

The service offered a variety of good quality food. Some patients said the food could be better and there were limited choices. One patient said it was the same each week however other patients said they liked the food and there was a choice. Patients said they had to order their menus 3 days in advance and sometimes changed their mind or forgot what they had ordered.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. The 'Workbridge' education and work project operated within the hospital. Patients' records showed that patients attended sessions there and had improved their reading and writing skills. Staff said that patients could also access courses outside the hospital such as bricklaying to improve their skills.

Staff helped patients to stay in contact with families and carers. Patients said their families could visit if they wanted to and they met them in the visitor's room. They also said they met with them during their authorised leave from the hospital.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients said they had social events in the hospital such as Christmas parties. They were encouraged to go onto the community as part of their authorised leave.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Patients were supported where needed to have mobility aids and promote their independence. Where wards were upstairs there were lifts and an evacuation chair in case of fire.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. We saw information displayed on each ward we visited. Patients told us they had the information they needed.

The service had information leaflets available in languages spoken by the patients and local community. These were available on the wards and included information about prescribed medicines.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us they could access interpreters and signers when needed.

The service did not always provide a variety of food to meet the dietary and cultural needs of individual patients. Two patients said they did not have foods that met their cultural needs however other patients said the food was good and reflected their cultural needs.

Requires Improvement

Forensic inpatient or secure wards

Patients said they did not always have access to spiritual, religious and cultural support. Two patients said they were not able to attend their places of worship. However, they said chaplains visited the hospital.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they knew how to complain. Complaints information requested from the provider showed that relatives had made complaints.

The service clearly displayed information about how to raise a concern in patient areas. On all the wards we visited we saw information displayed on how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff were aware of the complaints policy and what to do if a patient made a complaint to them.

Managers investigated complaints and identified themes. Information requested from the provider showed that complaints were investigated and themes of these were identified.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff spoken with said they would not discriminate against a patient who raised a complaint. Patients said they had not been discriminated against when they raised a complaint.

Staff knew how to acknowledge complaints however patients did not always receive feedback from managers after the investigation into their complaint. 2 patients told us they had not had a response to their complaint

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff said this was shared in staff meetings.

The service used compliments to learn, celebrate success and improve the quality of care. Staff meeting minutes showed that staff were congratulated on work they had completed with patients and positive themes were shared.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Local leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff said ward managers and general managers were visible and approachable. However, staff said they did not see managers from the provider's head office in Northampton and this impacted on their awareness of how the hospital operated.

Requires Improvement

Forensic inpatient or secure wards

Vision and strategy

Staff knew and understood the provider's vision and values but felt disconnected from the provider's head office in Northampton.

Staff said they were aware of the provider's vision and values but often felt disconnected from senior leaders at the provider's head office. They said that the vision and values were embedded in their work on the wards. However, there was a difference between the sites and the local area, and they felt this was not always acknowledged They expressed frustration about orders and funding being delayed and access to training as this was usually managed at Northampton.

Culture

Staff felt respected, supported and valued by their ward and general managers. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued by their managers on site but not always by the provider as they felt disconnected and not always valued.

Staff said they had opportunities for development and career progression although sometimes they did not get time to do this. Staff said they felt supported by the ward and general managers but above that managers did not always listen to their concerns. They said that at times staff felt 'burnt out' but were not listened to by senior leaders.

Staff said they were aware of the Freedom to Speak up process and felt confident to raise concerns of they needed to. They said their concerns would be listened to by local managers.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level which meant performance and risk were not always managed well.

The provider had governance systems in place and ward managers had access to a dashboard with live information about performance and risk. However, findings from our inspection showed that medicine management issues had not been identified, that staff said they felt 'burnt out', sufficient staff had not received training in basic life support and records did not show patients were involved in their care planning and therapeutic activities to aid their treatment.

The provider had recently reviewed staffing at the hospital and managers told us this was informed by clinicians. This had created a new Clinically Informed Staffing Dashboard (CIS) which was launched at the time of our inspection. This dashboard replaced the previous Operational Staffing Dashboard and was in response to frontline feedback that the previous process to adjust staffing levels felt very manual and time consuming, with various layers of approval required. The new dashboard automatically updated ward staffing levels following any changes to patients enhanced observations, seclusion or occupancy, by pulling the information directly from the patients' electronic care records and the patients care plans. Every ward dashboard was different depending on their assessed baseline staffing and budget.

The automatic algorithm was increased and decreased as staffing levels moved up or down according to patient need. The provider said this reduced the need for time consuming conversations and was responsive to the changing ward needs. At the time of inspection staff felt they had their staffing reduced and could not see the benefits of the new system or how it would reduce their stress levels.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and had started to use that information to good effect.

The new dashboard which had started the day before our inspection gave ward managers the information they needed about staffing, performance and risk.

Each morning there was a 'huddle' meeting which included the ward managers and security staff to discuss risks in the hospital and staffing.

Each ward had a clinical governance meeting at the start of each month. Minutes of these were kept and dates for action with who is responsible for action noted. There was a hospital clinical governance meeting a fortnight later where these actions were reviewed. Managers said they were looking to improve the format of clinical governance meetings to match the data available.

Staff were not able to submit risks to the risk register directly but did this via the ward manager.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The new staffing dashboard was aligned to the patients' electronic care record system and patients' care plans. This automatically generated information to determine the staffing levels needed for each ward based on the patient's clinical needs.

There were several quality improvement projects running at the hospital which staff had initiated. These included improving access to physical health clinics in the hospital to reduce the need to take patients to several hospitals and surgeries across the city. There was a project looking at reducing patient observation levels to enable least restrictive practice. Another was improving patient daily summaries to make these more meaningful for the patient and involving the patient in writing their daily summaries. Staff were working on this with the patient champion and clinical inequalities lead so this work could be co-produced.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff engaged with the local commissioners for secure services Reach Out collaborative and had secured funding for new posts within the hospital. These included a dedicated co-production lead to develop robust patient feedback

mechanisms with patients, families, and carers. To address the issues related to drug misuse, they have secured a full-time specialist drug worker post. This worker will focus on prevention, education, and harm reduction for both staff and patients and engage with external drug misuse services, to ensure seamless support transitions for patients leaving the hospital.

They also had funding for a full-time dialectal behavioural therapy (DBT) specialist post to enhance existing DBT services, particularly for male patients in the medium secure service. The aim was for DBT specialist when in post to contribute to train-the-trainer training, offer necessary clinical supervision, and strengthen the focus on patients with personality disorders, supporting their recovery journeys and facilitating earlier discharge.

They also have funding for an admission and discharge liaison post to work with the forensic intensive recovery team and local community services.

The Reach Out Collaborative have also supported funding to create a post for an Advanced Nurse Practitioner for Older Adults on Lifford ward to address the complex physical health issues of the older adult population. This will focus on patients' frailty and physical health care needs and provide an additional career pathway for registered nurses within the service.

Staff from a local NHS medium secure unit were completing reviews of patients care plans at the hospital. This was to benchmark against the standard and to discuss where improvements could be made.

Learning, continuous improvement and innovation

Managers told us they had trained some staff to be safeguarding navigators who championed safeguarding on the wards and provided additional training to the mandatory online training.

The provider had responded to Regulation 28 reports from the coroner. As a result, they had trained staff in using the Waterlow tool to measure patients' risk of developing a pressure ulcer. We saw care plans in place to monitor patients risks of this and action taken where needed to reduce the risk.

They had also responded to the coroner concerns about illicit substances being brought into the hospital. They had secured funding for a band 6 substance misuse worker to be based at the hospital. They had developed links with the local substance misuse service who provided training to staff on recognising signs of substance use and understanding addiction. They had also provided education to patients on the impact of substances on their mental health, physical well-being, and recovery process.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure that patients are involved in their care plans and their views are reflected. The provider must ensure that care plans include restrictions and plans for discharge. The provider must ensure that all patients are offered regular therapeutic activities as part of their care and treatment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure medicines administration records are up to date and accurate and that when staff are administering medicines they are doing so under their personal login. The provider must ensure they follow their medicine policy and national guidance to ensure that two signatures are recorded in the CD register when handling CDs. The provider must ensure that there are systems in place to ensure that all patients are supported to make a decision about whether they would like to be resuscitated or not and this decision is recorded and reviewed. The provider must ensure that systems are robust to ensure sufficient numbers of staff are deployed to ensure safe staffing levels on each ward. The provider must ensure that governance systems are strengthened to ensure they assess, monitor and improve the quality and safety of the services provided.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that sufficient staff are trained in basic life support to ensure there are always trained staff on each ward. The provider must ensure that all patients risk assessments are reviewed following an incident.