St Andrew's Healthcare - Birmingham

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding
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.

Summary of findings

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

Overall summary

We rated St Andrew's Healthcare Birmingham as good because:

- Staff treated patients well, taking the time to listen to their concerns and were sensitive to patient issues. Patients said they felt staff understood their individual needs. Patients told us they were actively involved in care planning and risk assessment and this was evident in care plans.
- Staff ensured that the admission process informed and orientated patients to the ward and the service. Staff displayed posters in communal areas alerting patients to the daily activities and meetings for the ward.
- Staff completed comprehensive care plans which demonstrated good practice. We saw evidence that staff followed National Institute for Health and Care Excellence guidance when providing therapy and prescribing medication.
- A dedicated physical healthcare team provided effective and timely physical healthcare to patients. The team provider tailored services to meet the needs of individual people and services were delivered in a way to ensure flexibility, choice and continuity of care.
- Managers ensured that staff received mandatory training. Staff were appraised annually and supervised monthly.
- Managers ensured shifts were covered by enough staff of the right grades and experience, and that staff maximised shift-time on direct care activities.
- The provider demonstrated a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met these needs and promoted equality. The provider used interpreters to ensure that patients could communicate if they did not speak or understand English. The provider also worked with catering so that the food provided met patients' cultural needs with respect to diet. The provider had a RACE (Race, Culture and Ethnicity) group which looked at ways that patients from different ethnic backgrounds could be supported. The chaplaincy department ran an awareness session on Ramadan and worked with catering on what foods to serve post fasting.
- Staff provided information in other languages and there were some examples of wards buying in newspapers, CDs and books in different languages to enable patients to keep connected to their cultural identity. The chaplaincy department carried out an exercise to establish patient feedback on how the provider met their spiritual needs.
- Managers planned the services to integrate with other organisations and the local community and ensured that services meet people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.

However:

- The provider had not mitigated all risks posed to the quality of stored medication by broken air conditioning. On Hurst ward, and in the separate physical healthcare clinic room, the ambient room temperature was 29.8 degrees centigrade. In the months of May and June 2018, the provider had recorded temperatures above the maximum 25 degrees centigrade on each day between 5 May 2018 and the day of the inspection, yet had continued to dispense medication from these rooms. There was a risk that medication may become less effective if stored at the incorrect temperature.
- The seclusion room on Speedwell ward had been damaged on 8 June 2018 and therefore was not in use. Hurst seclusion room was not in use due to the air conditioning not working. This meant that, if staff decided that a patient should be secluded, they would have to use the facility on another ward.
- Managers had not ensured a safe environment on Speedwell. The lock to the staff office door had been damaged on 1 June 2018. This meant that staff had to

Summary of findings

use a key to lock the door rather than it locking automatically on closing. There was a risk that staff may forget to lock the door as they entered or left the office. This could allow patients to access confidential information. Also, it would take staff longer to respond to incidents because staff had to lock themselves in the office and so would have to unlock the door to get out to attend an incident.

- On Lifford and Edgbaston wards there was a delay in referrals to urology for two patients who had markers indicating they could have prostate cancer. This meant that there was a risk of a delay in diagnosing a potentially treatable cancer.
- Staff had not completed appropriate care plans for one patient on Speedwell ward, with complex needs and behavioural issues. We found there was no positive behavioural support plan for staff to follow and an inconsistent approach to assessment and care planning for this patient. Staff demonstrated a lack of understanding of the patient's needs.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Good	
Wards for people with learning disabilities or autism	Good	

Summary of findings

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Good

St Andrew's Healthcare Birmingham

Services we looked at:
Forensic inpatient/secure wards; Wards for people with learning disabilities or autism.

Summary of this inspection

Background to St Andrew's Healthcare - Birmingham

St Andrew's Healthcare is a registered charity. St Andrew's Healthcare Birmingham is an independent hospital which provides medium and low secure support for people with mental health needs and / or associated learning disabilities or autistic spectrum disorders. The hospital is registered to accommodate up to 128 people and is made up of eight wards. Seven wards accommodate patients with forensic mental health needs and one ward accommodates men with learning disabilities and autism:

Edgbaston 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 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 with learning disabilities and autistic spectrum disorder.

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 three times. The last inspection was carried out on 10 October 2015 when the hospital was rated as good.

Our inspection team

The team that inspected the service comprised one CQC inspection manager, two CQC inspectors and specialist advisors including two forensic nurses, an occupational therapist, and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

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

During the inspection visit, the inspection team:

Summary of this inspection

- visited all eight wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 19 patients who were using the service
- spoke with the registered manager and managers or acting managers for each of the wards
- spoke with 68 other staff members; including doctors, nurses, occupational therapists, psychologists, healthcare assistants and social workers
- attended and observed two hand-over meetings and two multi-disciplinary meetings
- collected feedback from 8 patients using comment cards
- spoke with two carers of patients who used the service
- looked at 42 care and treatment records of patients
- carried out a specific check of the medication management on all wards 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 that that they felt safe at St Andrew's Birmingham, that staff treated them well, taking the time to listen to their concerns and were sensitive to patient issues. Patients said they felt staff understood their individual needs. Carers told us they felt involved in their relative's care.

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?

Requires improvement 

We rated safe as requires improvement because:

- The seclusion room on Speedwell ward had recently been damaged and therefore was not in use. Hurst seclusion room was not in use due to the air conditioning not working. If patients needed seclusion they would have to use the facility on another ward. Moving distressed patients through wards and corridors to alternative seclusion rooms carried a risk of harm to patients and staff. The provider had arranged repairs to both seclusion facilities but staff had been waiting for over a month for repairs to be carried out.
- Managers had not ensured a safe environment on Speedwell ward. The lock to the staff office door had been damaged meaning that staff had to use a key to lock the door. There was a risk that staff may forget to lock the door as they entered or left the office, leaving patients able to access confidential information, or that it would take staff longer to respond to incidents due to having to unlock the door.
- The provider had not mitigated all risks posed by broken air conditioning. On Hurst ward and in the separate physical healthcare clinic room the ambient room temperature was 29.8 degrees centigrade. In the months of May and June 2018 the provider had recorded temperatures above the maximum 25 degrees centigrade from 5 May 2018 to the time of inspection, yet had continued to dispense medication from these rooms. There is a risk that medication may become less effective if stored at the incorrect temperature.

However:

- The layout of all wards allowed staff to observe of all parts of the wards.
- Managers had completed ligature risk assessments, identified all ligature risks and mitigated against these through observation procedures.
- Staff completed risk assessments of every patient on admission and updated these regularly and after every incident.
- Doctors provided medical cover day and night and could attend the ward quickly in an emergency.
- Managers ensured that staff had received and were up to date with appropriate mandatory training and the mandatory training rate for staff was 93%.

Summary of this inspection

- The provider focused on reducing restrictive practice. From the evidence we reviewed, we concluded that staff used restraint only after de-escalation has failed and using correct techniques, all permanent and regular bank staff were trained in the management of actual or potential aggression.

Are services effective?

Good

We rated effective as good because:

- Staff completed care plans that demonstrated good practice. We reviewed 42 care records and 41 evidenced this. We saw evidence that staff took account of National Institute for Health and Care Excellence guidance when prescribing medication.
- Staff offered recommended psychological therapies for post-traumatic stress, sex offender work, anger management and recognising emotions, fire setting work, and support to patients who self-harm.
- A dedicated physical healthcare team provided effective and timely physical healthcare to patients. Staff used recognised rating scales to assess and record severity and outcomes such as the Health of the Nation Outcome Scales for secure services, the Beck Depression Inventory, the Beck Anxiety Inventory, the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM). Occupational therapists used the Vonda Du Toit Model of Creative Ability and the Model of Human Occupation. Lead occupational therapists were involved in the writing of latest research using these tools alongside local universities.
- Clinical staff participated actively in clinical audit of care records, we saw that care plans and positive behavioural support plans were updated in line with these audits. The provider also involved patients in the decisions about which areas should be audited.
- Staff participated in regular effective multi-disciplinary meetings and effective handovers. We observed a multi-disciplinary meeting which was very patient focused. We observed a handover and saw a dedicated handover template with key areas to be discussed for each patient at the start and end of each shift, including risks, behaviour, patient's presentation and a "positive message".
- Staff had effective working relationships with other teams and stakeholders. The provider told us about joint working with two local NHS trusts to support patients along the recovery pathway and out into the community.

However:

- Staff had not completed appropriate care plans for one patient on Speedwell ward, with complex needs and behavioural

issues. We found there was no positive behavioural support plan for staff to follow and an inconsistent approach to assessment and care planning for this patient. Staff demonstrated a lack of understanding of the patient's needs.

Are services caring?

Good

We rated effective as good because:

- Staff treated patients well, taking the time to listen to their concerns and were sensitive to patient issues. Patients told us that they felt staff understood their individual needs. Patients told us they were actively involved in care planning and risk assessment and this was evident in care plans.
- Patients reported that they felt staff understood their individual needs.
- Staff ensured that the admission process informed and orientated patients to the ward and the service. Staff displayed posters in communal areas alerting patients to the daily activities and meetings for the ward.
- Patients told us they were actively involved in care planning and risk assessment and this was evident in care plans.
- Patients had access to advocacy and there were posters displayed near the ward telephone giving details of how they could be contacted.
- The two carers that we spoke with told us they felt involved in their relative's care. There was a visitors' suite near the hospital entrance and families could also use the café with their relative.
- Patients were encouraged to give feedback on the service they received at weekly community meetings and via a patient feedback survey.

However:

- Patients told us the provider occasionally had too few staff on duty to fulfil requests for leave that required a staff member to escort the patient.
- Patients on Edgbaston ward felt there was a "them and us" culture between staff and patients, but they acknowledged that managers were working with staff and patients to dispel this.

Are services responsive?

Outstanding

We rated responsive as outstanding because:

- The provider tailored services to meet the needs of individual people and delivered them in a way to ensure flexibility, choice and continuity of care. One example was the employment of a teacher who linked with local education providers to support patients to build skills relevant for when they moved on from

services. In addition, patients had access to a physical healthcare suite which mirrored healthcare services in the community. Patients made their own appointments and were seen outside the ward environment.

- The provider understood the needs of different groups of people and delivered care in a way that met these needs and to promote equality and diversity. This included access to quiet areas for prayer and access to appropriate cultural diets. The provider also had an established RACE (Race, Culture and Ethnicity) group who reviewed ways in which patients from different ethnic backgrounds could be supported. Chaplaincy staff held cultural awareness sessions and provided advice and guidance to catering staff on food to serve post fasting.
- The provider encouraged patients to personalise their bedrooms and supported patients to have access to games consoles and items which supported their recovery. This included furnishing bedrooms with sensory equipment to help patients relax.
- Staff provided information in an accessible format and ensured patients had access to other forms of media in different languages. This included newspapers, CD's and books to enable patients to keep in touch with their cultural identity.
- The provider actively reviewed complaints and involved patients and staff in how they were resolved and responded to, improvements were made as a result across the service.
- Managers planned the services to integrate with other organisations and the local community and ensured that services met people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The provider had worked with local stakeholders to form a "Reach Out" group to look at local care provision, and establish recovery orientated discharge pathways. This enabled patients to continue using the skills they learnt in when discharged into the community.

Are services well-led?

Good

We rated well-led as good because:

- Managers ensured that team objectives reflected the organisation's vision and values. Managers displayed their ward values on the walls in patient areas and patients had been involved in writing these values.
- Staff knew who the most senior managers in the organisation were and these managers visited the wards on a regular basis. Managers ensured that staff received mandatory training and

Summary of this inspection

were appraised annually and supervised monthly. Managers ensured that shifts were covered by enough staff of the right grades and experience, and staff maximised shift-time on direct care activities.

- Staff participated in clinical audits and patients were also involved in suggesting which aspects of care should be prioritised for audit.
- Staff reported incidents and managers ensured that staff learnt from incidents, complaints and patient feedback.
- Staff told us they knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. The majority of staff spoke of having good morale, job satisfaction and sense of empowerment. Staff told us the provider had excellent resources for external staff support such as counselling services. Pastoral care for staff was also provided by the chaplaincy service.

However:

- The provider had made some changes to the roles and responsibilities of staff in the senior management team and not all staff were aware of these changes.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- The provider had a dedicated centralised Mental Health Act team including an administrator who examined Mental Health Act (1983) papers on admission. Staff knew who the administrators were and could get support to ensure that the Act was followed in relation to, for example, renewals, consent to treatment and appeals against detention.
- Staff kept clear records of leave granted to patients. Patients, staff and carers were aware of the conditions of leave granted, including risk and contingency/crisis measures.
- The provider developed a combined mandatory training module on The Mental Health Act (1983), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. 76% of staff had completed this training.
- Staff adhered to consent to treatment and capacity requirements and copies of consent to treatment forms were attached to medication charts, where applicable.
- Staff read patients their rights under the Mental Health Act explained to them on admission and routinely thereafter.
- Staff completed detention paperwork and ensured it was filled in correctly, up to date and stored appropriately.
- Staff carried out regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits.
- Managers ensured patients had access to Independent Mental Health Advocate services. Staff were clear on how to access the advocacy service to support patients with capacity issues, or access to wards and records. Staff displayed posters with the names and contact details of the mental health advocacy services.

However:

- Staff had not always informed carers when their relative was secluded. This happened on 11 out of 14 occasions of records reviewed.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were trained in and had a good understanding of Mental Capacity Act (2005), including the five statutory principles. The provider had a policy on the Mental Capacity Act (2005) including Deprivation of Liberty Safeguards which staff are aware of and can refer to on the intranet.
- Staff completed capacity assessments for patients who might have impaired capacity. Staff assessed and recorded capacity to consent appropriately. This was done on a decision-specific basis with regards to significant decisions. Staff assisted patients to make a specific decision for themselves before they were assumed to lack the mental capacity to do this.
- Staff made decisions for patients who lacked capacity, in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty Safeguards. At the time of inspection all patients in the hospital were detained under the Mental Health Act (1983) so no Deprivation of Liberty Safeguards applications had been made.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Good	Good	☆ Outstanding	Good	Good
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	☆ Outstanding	Good	Good
Overall	Requires improvement	Good	Good	☆ Outstanding	Good	Good

Good

Forensic inpatient/secure wards

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Good

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- The layout of all wards allowed staff to observe of all areas.
- Managers completed ligature assessments, had identified all ligature risks and mitigated against these through observation procedures.
- 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.
- Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that were checked regularly. However, on Hurst ward and in the separate physical healthcare clinic room the ambient room temperature was 29.8 degrees centigrade. In the months of May and June 2018 the provider had recorded temperatures above the maximum 25 degrees centigrade from 5 May 2018, yet had continued to dispense medication from these rooms. There is a risk that medication may become less effective if stored at the incorrect temperature. We raised this with the provider and were informed that the air conditioning had broken in April 2018, and they were awaiting a part which was due imminently but there had been a national shortage of this part. The provider had placed a mobile air conditioning unit in the room but this was not sufficient to bring the temperature down. When we raised the issue during inspection the provider made alternative arrangements for the safe storage of medication.
- We looked at seven seclusion rooms: Edgbaston; Hawksley, Hazelwell, Hurst, Lifford, Northfield, Moor Green. Hurst seclusion room was not in use due to the air conditioning not working. All other seclusion rooms met the Mental Health Act (1983) Code of Practice.
- All ward areas were clean, had good furnishings and were well-maintained.
- Staff adhered to infection control principles including hand washing. Cleaning records were up to date on all wards and demonstrated that wards were regularly cleaned.
- Staff ensured that equipment was well maintained and clean. We saw that clean stickers were visible and in date.
- Managers completed regular environmental risk assessments for all wards and staff knew where ligature assessments and ligature cutters were located on the wards.
- Throughout the hospital staff and visitors had access to appropriate alarms and there were nurse call systems in assisted bathrooms.

Safe Staffing

- The provider had a high number of unfulfilled shifts. During the three months from 1 January to 31 March 2018, 351 shifts (21%) were unfulfilled across forensic secure wards. Managers covered 1039 shifts (63%) with bank staff from the provider's own bureau and 268 shifts (16%) from agency staff.
- The ward that used highest numbers of bank and agency staff was Lifford ward. On Lifford ward there were 68 (21%) unfilled shifts, 209 (65%) shifts were filled with bank staff from the provider's own bureau, and 45 (14%) shifts were filled with agency staff.

Good

Forensic inpatient/secure wards

- The provider had establishment levels of 75 registered and 99 unregistered staff across forensic secure wards. There were nine vacancies for registered staff: three of these were for Edgbaston ward, two on Hazelwell ward, two on Northfield ward, one on Hawksley ward and one on Hurst ward. The provider had four vacancies for unregistered staff across forensic secure wards. Northfield ward had vacancies for one full time and one part time health care assistant, Hurst ward had a vacancy for a full-time healthcare assistant and Edgbaston and Hawksley wards both had vacancies for part time health care assistants.
- The provider invested in a dedicated workforce planning team using a recognised safer staffing tool. This work had started in August 2017. All wards had been assessed to define and confirm safe staffing numbers, optimum staffing numbers and ward establishment numbers. The planning team had also assessed optimum therapeutic numbers for the multidisciplinary team.
- Ward managers could adjust staffing levels daily to take account of case mix. Managers met each morning with the senior management team to discuss daily risk issues for their wards and adjusted staffing levels where necessary.
- A qualified nurse was always present in communal areas of the ward.
- We saw in care records that there were enough staff so that patients could have regular 1:1 time with their named nurse.
- Escorted leave or ward activities were rarely cancelled because there were too few staff.
- A dedicated physical healthcare team consisting of a non-medical prescriber, a paramedic and healthcare assistants ensured physical healthcare interventions were carried out safely.
- Doctors provided adequate medical cover day and night and could attend the ward quickly in an emergency.
- Managers ensured staff had received and were up to date with appropriate mandatory training and the mandatory training rate for staff was 93%.

Assessing and managing risk to patients and staff

- From 1 October 2017 to 31 March 2018, there were 29 episodes of seclusion across forensic secure wards. These were highest on Moor Green ward with 13 seclusions.
- From 1 October 2017 to 31 March 2018, there were 67 episodes of restraint. These were highest on Lifford ward with 31 restraints for two different patients. Moor Green had 18 episodes of restraint for five different patients. Over the same period there were four episodes of prone restraint. These were highest on Hazelwell ward with two episodes of prone restraint.
- We examined 35 patient records, all showed that staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident.
- Staff used the short-term assessment of risk and treatability screening tool, and the Historical Clinical Risk Management -20 tool, both tools are nationally recognised risk assessment tools.
- All patients being treated on forensic inpatient secure wards were detained under the Mental Health Act (1983).
- We observed good policies and procedures for observation were in place, including to minimise risk from ligature points and searching patients.
- The provider focused on reducing restrictive practice. From the evidence we reviewed, we concluded that staff used restraint only after de-escalation had failed and using correct techniques. All permanent and regular bank staff were trained in the management of actual or potential aggression. The use of rapid tranquilisation was rare but when it was necessary staff followed National Institute for Health and Care Excellence guidance on administration of rapid tranquilisation medication.
- We saw in care records that seclusion was used appropriately and followed best practice. The records for seclusion were kept in an appropriate manner.

Track record on safety

- This core service reported 27 serious incidents in the last 12 months.
- The most common reason for serious incidents was patient violence and aggression and allegations about staff management of these. The provider has responded by moving to management of actual and potential aggression training with a view to reducing the allegations of abuse against staff. The provider recognised that the previous approach to management of aggression and violence was overly restrictive. They had re trained 100% of clinical staff across the hospital which, along with other initiatives, decreased the use of restrictive interventions.

Good

Forensic inpatient/secure wards

Reporting incidents and learning from when things go wrong

- Staff told us they knew what to report and how to report. All incidents that should be reported were reported on an electronic database.
- Staff were open and transparent and explained to patients when things went wrong.
- Staff told us they received feedback from the investigation of incidents in their clinical area but were not aware of incidents external to the service. There was evidence of red top alert posters on wards highlighting current risk issues. Discussion took place about serious incidents in board level meetings, however we noted that incidents were not routinely discussed at ward team meetings.
- Managers held daily morning meetings to discuss any serious incidents from overnight or the previous day. Actions from these meetings were disseminated to staff via email.
- Managers debriefed staff and offered them support after serious incidents.

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Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff completed care plans that demonstrated good practice. We examined 35 care records for this core service; records were holistic and written in the patient's own language indicating their involvement in the assessment and care planning process. Staff had completed a comprehensive and timely assessment for each patient after admission.
- Staff had completed physical examinations for patients and there was ongoing monitoring of physical health problems. However, on Lifford and Edgbaston wards there was a delay in referrals to urology for two patients who had markers indicating they could have prostate cancer. This meant that there was a risk of a delay in diagnosing a potentially treatable cancer.
- All information needed to deliver care was stored securely and available to staff when they needed it, in an accessible form; including when people move between teams. The provider used an electronic patient records system but also kept paper copies of patients' personal behavioural support plans so that care plans were always accessible, including to bank and agency staff. We saw that patients had copies of these.

Best practice in treatment and care

- All 35 care records that the team examined demonstrated good practice. We saw evidence that staff followed National Institute for Health and Care Excellence guidance when prescribing medication.
- Staff offered recommended psychological therapies for post-traumatic stress, sex offender work, anger management and recognising emotions, fire setting work, and to support patients who self-harmed.
- A dedicated physical healthcare team ensured patients had good access to physical healthcare. The team structured appointments for patients as they would in the community. The physical healthcare team benchmarked their service in line with GP practices to provide screening programmes for chronic diseases, diabetes management, and triple aortic aneurism screening in older patients. Staff told us they would refer to specialists when needed, although said there had been difficulties with NHS services not always accepting referrals in a timely manner. Staff told us that NHS services had been slow to take referrals. The team leader for the physical healthcare team was working with commissioners to improve access to external services.
- Staff assessed and met patients' nutrition and hydration needs. This was evidenced in care records reviewed.
- Staff used recognised rating scales to assess and record severity and outcomes such as the Health of the Nation Outcome Scale for secure services, the Beck Depression Inventory, the Beck Anxiety Inventory, the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM). Occupational therapists used the Vonda Du Toit Model of Creative Ability and the Model of Human Occupation. Lead occupational therapists were involved in the writing of latest research using these tools alongside local universities.

- Clinical staff participated in clinical audit of care records, we saw that staff updated care plans and positive behavioural support plans in line with these audits. The provider also conducted quarterly audits of clinic rooms and the electronic prescribing system.

Skilled staff to deliver care

- The provider had the full range of disciplines needed to deliver care including, nurses, occupational therapists, clinical psychologists, a teacher, social workers, healthcare assistants and activities coordinators. However, staff told us that there was reduced experienced occupational therapy presence in the multidisciplinary team because recent staff changes meant experienced staff had left and been replaced with newly qualified staff.
- We spoke with several recently qualified staff during inspection, they told us that they received an appropriate induction, and healthcare assistants we spoke with told us that the Care Certificate standards were used as the benchmark for healthcare assistants' induction.
- Managers ensured that staff received regular supervision appraisal and had access to regular team meetings. All non-medical staff had received an appraisal in the last 12 months.
- The provider's learning and development department provided staff access to the necessary specialist training for their roles. However, we spoke to three newly qualified staff who told us that it had been difficult to get access to training as the training was often facilitated at another of the provider's locations and had been cancelled frequently.
- We saw evidence in staff files that managers addressed poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- Staff participated in regular, effective multi-disciplinary meetings. We observed one of these and found that the meeting was very patient focused.
- Staff attended effective handovers within teams. Each ward had a dedicated handover template with key areas to be discussed for each patient at the start and end of each shift, including risks, behaviour, patients' presentation and a "positive message".
- Staff had effective working relationships with other teams and stakeholders. The provider told us about joint working with two local NHS trusts to support patients along the recovery pathway and out into the community. In addition to ensuring good handovers for patients who were moving on, the provider was linking up with other stakeholders to promote the work they do and create new joint pathways, such as community support which would be facilitated by all stakeholders.

Adherence to the Mental Health Act (1983) and the Mental Health Act (1983) Code of Practice

- The provider had a dedicated centralised Mental Health Act team including an administrator who examined Mental Health Act (1983) papers on admission. Staff knew who the administrators are and could get support to ensure that the Act is followed in relation to, for example, renewals, consent to treatment and appeals against detention.
- Staff kept clear records of leave granted to patients. Patients, staff and carers were aware of the conditions of leave granted, including risk and contingency/crisis measures. However, we reviewed 14 seclusion records for this core service and noted that in 11 records staff had not informed carers that their relative was secluded.
- The provider developed a combined mandatory training module on The Mental Health Act (1983), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. 76% of staff had completed this training.
- We saw that staff adhered to consent to treatment and capacity requirements and kept copies of consent to treatment forms attached to medication charts where applicable.
- It was demonstrated in patient records that staff explained patient's rights under the Mental Health Act to them on admission and routinely thereafter.
- Staff completed detention paperwork correctly, kept it up to date and stored it appropriately.
- Staff carried out regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits.
- Staff endured that patients had access to Independent Mental Health Advocate services. Staff were clear on how to access the advocacy service to support patients with capacity issues, or access to wards and records. Staff displayed posters with the names and contact details of the mental health advocacy services.

Good practice in applying the Mental Capacity Act (2005)

Good

Forensic inpatient/secure wards

- Staff were trained in and had a good understanding of Mental Capacity Act (2005), the five statutory principles. The provider had a policy on the Mental Capacity Act (2005) including Deprivation of Liberty Safeguards which staff are aware of and can refer to on the intranet.
- Staff had completed capacity assessments for patients who might have impaired capacity., Staff had assessed and recorded capacity to consent appropriately. This was done on a decision-specific basis with regards to significant decisions. Staff assisted patients to make a specific decision for themselves before they were assumed to lack the mental capacity to do this.
- Staff made decisions for patients who lacked capacity, in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty Safeguards. At the time of inspection all patients in the hospital were detained under the Mental Health Act (1983) so no Deprivation of Liberty Safeguards applications had been made.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed positive staff attitudes and behaviours when interacting with patients. Staff were responsive, discreet, respectful, and provided appropriate practical and emotional support.
- Patients on most wards told us that staff treated them well taking the time to listen to their concerns and were sensitive to patient issues. However, patients on Edgbaston ward said they felt that there was a "them and us culture" between staff and patients and that there was inconsistency amongst staff attitudes towards patients.
- Patients told us staff understood their individual needs but occasionally lacked staff to fulfil requests for leave.

The involvement of people in the care they receive

- Staff ensured that the admission process informed and orientated patients to the ward and the service. Staff displayed posters in communal areas alerting patients to the daily activities and meetings for the ward.
- Patients told us they were actively involved in care planning and risk assessment and this was evident in care plans.
- Patients had access to advocacy and there were posters displayed near the ward telephone giving details of how they could be contacted.
- Carers told us they felt involved in their relative's care. There was a visitors' suite near the hospital entrance and families could also use the on-site café with their relative.
- Patients gave feedback on the service they received at weekly community meetings and via a patient feedback survey. The patient survey undertaken in February and March 2018 comprised of various themes, including: care planning, staff support and interaction, environment, physical health, advocacy, treatment and care. Overall, the response rate had improved by 11% from the previous survey. The provider received 37 responses which equates to a 30% response rate. Questions responded to positively were ward cleanliness, assessment of physical health needs, supportive staff, feeling safe and being treated with dignity and respect. The survey results suggested scope for further improvements in areas such as; involvement with care planning on some wards, time spent with their care co-ordinator, and information about medicine and advocacy. The provider told us that they are in the process of developing an action plan in response to the highlighted issues.
- Patients could be involved in decisions about the service and had been involved in the recruitment of staff.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Outstanding

Access and discharge

Good

Forensic inpatient/secure wards

- The average bed occupancy in this core service over the last 6 months was 98%. All wards had a bed occupancy of more than 85%
- Over the past 12 months there were no patients admitted whose home address was more than 50 miles away. The average length of stay way 1080 days for Edgbaston ward, 866 days for Moor Green ward, 772 days for Hazelwell ward, 721 days for Northfield ward and 688 days for Hawkesley ward. There had been no discharges from Lifford or Hurst wards in the 12 months prior to inspection.
- On average patients waited five days from referral to assessment and the assessment would last up to 28 days before the onset of treatment.
- The provider did not admit new patients to beds which were occupied by patients on leave, ensuring patients always had access to a bed on return from leave.
- People were not moved between wards during an admission episode unless this was justified on clinical grounds and in the interests of the patient. When people were moved or discharged this happened at an appropriate time of day.
- In the last six months the provider reported no delayed discharges.
- Managers planned the services to integrate with other organisations and the local community and ensured that services met people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The provider had worked with local stakeholders to form a "Reach Out" group to look at local care provision, and establish recovery orientated discharge pathways. This enabled patients to continue using the skills they learnt in hospital, when discharged into the community.
- Care plans referred to identified section 117 aftercare services to be provided for those patients' subject to section 3 or equivalent Part 3 powers of the Mental Health Act (1983), authorising admission to hospital for treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider tailored services to meet the needs of individual people and these were delivered in a way to ensure flexibility, choice and continuity of care. The provider had a full range of rooms and equipment to support treatment and care and help patients build skills to support them when they moved on from services. The provider had a range of activity and therapy rooms, including a library, music room with recording studio, information technology suite, therapy kitchen, art therapy room and was in the process of building an occupational therapy hub which would in time provide patients with skills of heavy and light industry such as woodwork.
- The provider ensured there were quiet areas on the wards where patients could have time to think or pray and staff supported patients to attend the multi faith centre near the hospital entrance. This included a wudoo (a wudoo is a sink) where patients could wash their hands and feet before prayer. There was also a visitors' suite where patients could meet with visitors.
- The hospital provided a physical healthcare suite in addition to clinic rooms on each ward. The physical healthcare team or GP would examine patients in the suite. Managers had commissioned the physical healthcare service in a way that mirrored healthcare services in the community enabling patients to make their own appointments outside of the ward environment. The service would refer on to more specialist services if required.
- Patients could make a telephone call in private, each ward had a telephone in a private room, some patients were able to use mobile phones when on leave from the hospital.
- Patients had access to outside space, each ward had a garden and for the majority of wards access to fresh air was unrestricted. However, for patients on Hurst ward access to fresh air was scheduled at specific times due to the ward being located upstairs.
- Patients told us that food was of an acceptable quality, patients could choose meals from a weekly menu, purchase food from the onsite café, or if individually care planned could shop and cook in the therapy kitchen. Patients had access to hot drinks and snacks 24 hours a day, seven days a week and could order in take away food if they wished.
- The provider supported patients to personalise their bedrooms on all wards. Staff had individually risk assessed this to allow patients access to technology such as games consoles in their rooms, provided the patient consented to having their equipment appliance

tested and internet access restricted. We saw one room where a patient had been supported to furnish their room with sensory equipment which the patient told us helped them to relax.

- Patients could store most of their possessions in their rooms but there was also locked space provided for restricted items that were not permitted on the ward but could be used on leave from hospital.
- Staff provided activities for patients, including at weekends. Staff displayed activities planners were for patients to see on all wards.
- Staff put patient's individual needs and preferences as central to the planning and delivery of the service.
- The provider told us that across the hospital 54% of patients were white British, 16% were black, 11% were Asian and 3% were white other. The provider monitored the ethnic profile of wards particularly related to language and religion as these can impact on the response to diagnosis and treatment.
- The provider demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. The provider used interpreters to ensure patients could communicate if they did not speak or understand English, they also worked with catering so that their cultural needs were met with respect to diet. The provider had a RACE (Race, Culture and Ethnicity) group who looked at ways that patients from different ethnic backgrounds could be supported. The chaplaincy department ran an awareness session on Ramadan and worked with catering on what foods to serve post fasting.
- The provider had a representative proportion of black and ethnic minority staff and advocates that aligned with the patient population.
- Staff provided information in other languages and there were examples of wards buying in newspapers, CDs and books in different languages to enable patients to keep connected to their cultural identity. The chaplaincy department carried out an exercise to establish patient feedback on how the provider met their spiritual needs. We heard positive feedback from both staff and patients about this facility.
- Staff provided accessible information on treatments, local services, patients' rights, and how to complain.

Listening to and learning from concerns and complaints

- The provider actively reviewed complaints and involved patients and staff in how they were resolved and responded to, improvements were made as a result across the service. The provider reported that there were 17 complaints received in the 12 months from 1 April 2017 to 31 March 2018. Three of the complaints were upheld and none were referred to the ombudsman. Six of these complaints were from Hazelwell ward, one of which was upheld regarding the recording of incidents involving a patient.
- The service also received 21 compliments during the same period. Hurst ward received the most compliments with 12.
- The majority of patients knew how to complain and there was information detailing how to complain on all wards. However, patients on Moor Green ward told us they did not know how to complain.
- Staff knew how to handle complaints appropriately. Complaints were investigated promptly and staff received feedback on the outcome of investigation of complaints and acted on the findings. There was evidence of this in team meeting minutes and care records.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- Staff knew and agreed with the organisation's vision: to transform lives together. The values which underpin the vision and the provider's strategy were; compassion: be supportive; understand and care for patients, their families and all in the community. Accountability: take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: innovate, learn and deliver; whatever you do, do it well.
- The provider was in the process of introducing a value-based healthcare approach aimed at providing the best patient outcomes for the best investment. This involved the introduction of Integrated Practice Units to provide care to patients with similar clinical needs.

Good

Forensic inpatient/secure wards

- Managers ensured team objectives reflected the organisation's vision and values. Managers displayed their wards values on the walls in patient areas and patients had been involved in writing these values.
- Staff knew who the most senior managers in the organisation are and these managers visited the wards on a regular basis. The provider had made changes to the roles and responsibilities of staff in the senior management team and not all staff were aware of these changes.

Good governance

- Managers ensured that staff received mandatory training and were appraised annually and supervised monthly.
- Staff participated actively in clinical audits and patients were also involved in suggesting which aspects of care should be prioritised for audit.
- Staff reported incidents and managers ensured that staff learnt from incidents, complaints and service user feedback.
- Managers ensured that staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures.
- The provider used key performance indicators to gauge the performance of the team. One of the priorities was to train at least 90% of clinical and ward based staff in the use of management of actual and potential aggression. This was achieved with 100% of clinical staff having been trained. Another priority was to reduce the use of restrictive interventions. The use of seclusion has fallen from 9.2 to 6.6 per 1000 occupied bed days and the use of prone restraint from 6.6 to 4.1 per 1000 occupied bed days over the course of the year. The provider attributed this in part to using the Safewards model of managing conflict and containment, but also the close monitoring by the senior management team and the scrutiny of the provider's restrictive practice monitoring group, which met monthly.
- Ward managers told us they had sufficient authority to do their job and staff had the ability to submit items to the charity's risk register.

Leadership, morale and staff engagement

- The provider reported an employee engagement score of 64% in their 2017 staff survey.
- Sickness and absence rates amongst permanent staff were highest on Hazelwell ward at 4.6% and Northfield ward at 4.2%. Lifford ward had the lowest sickness rate at 1.9%.
- The provider did not report any bullying and harassment cases. Staff told us they knew how to use whistle-blowing process and felt able to raise concerns without fear of victimisation.
- The majority of staff spoke of having good morale, job satisfaction and sense of empowerment.
- The provider offered opportunities for leadership development.
- Staff were open and transparent and explained to patients when something went wrong.
- Staff told us they knew how to use whistle-blowing process and felt able to raise concerns without fear of victimisation.
- Staff told us the provider had excellent resources for external staff support such as counselling services. Pastoral care for staff was also provided by the chaplaincy service.
- Staff were offered the opportunity to give feedback on services and input into service development.

Commitment to quality improvement and innovation

- The provider is a member of the Quality Network for Forensic Mental Health Services and are reviewed annually by their peers. They are also accredited by The National Autistic Society.

Good

Wards for people with learning disabilities or autism

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Good

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- The layout of Speedwell ward allowed staff to observe all parts of ward.
- Managers completed ligature assessments, identified ligature risks and mitigated against these through observation procedures.
- Speedwell ward was male only and therefore complied with guidance on same-sex accommodation.
- Speedwell ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that were checked regularly.
- The seclusion room on Speedwell ward had recently been damaged and therefore was not in use. If patients needed seclusion they would have to use the facility on another ward. Moving distressed patients through wards and corridors to alternative seclusion rooms carried a risk of harm to patients and staff. However, this had not been necessary in recent days and staff showed us the maintenance log which showed that the damages to the seclusion room had been reported to the estates department and were prioritised for repair.
- The lock to the staff office door had been damaged meaning that staff had to use a key to lock the door to ensure patients could not open the office door and enter at will. There was a risk that staff may forget to lock the door as they entered or left the office, leaving patients able to access confidential information, or that it would take staff longer to respond to incidents due to having to unlock the door. We shared our concerns about this with the provider who immediately arranged for the door to be repaired with a self-locking door which could be opened from the inside with a twist lock.
- All other ward areas were clean, with good furnishings and well-maintained. The ward was purposefully sparsely decorated to provide a low stimulus environment for people with autistic spectrum disorder.
- Staff adhered to infection control principles including hand washing. Cleaning records were up to date on all wards and demonstrated that wards were regularly cleaned.
- Staff ensured equipment was well maintained; clean and clean stickers were visible and in date.
- Managers completed regular environmental risk assessments and staff knew where ligature assessments and ligature cutters were located on the ward.
- Throughout the hospital staff and visitors had access to appropriate alarms and there were nurse call systems in assisted bathrooms.

Safe Staffing

- The provider had a high number of unfulfilled shifts. During the period from 1 January to 31 March 2018 Speedwell ward had 82 (19%) unfulfilled shifts. Managers used bank staff from the provider's bureau to cover 267 (60%) shifts and agency staff to cover 95 (21%) shifts.
- Speedwell ward had a staffing establishment of 12 registered staff, 15 unregistered staff and a vacancy for one part-time and one full time healthcare assistant.
- The provider told us that they had used over 20% of bank and agency as part of the staff group on Speedwell ward due to a recent patient admission that required additional staffing input. Managers told us that agency

staff were block booked and they used staff that were specifically trained to deal with the patient group, so the same staff would regularly attend the one ward. The provider also told us that if a ward had more than two agency staff, the agency staff would be swapped with a permanent staff member form another ward. The provider worked with the agency to ensure the agency staff booked had specific skill sets, such as learning disability experience.

- The provider invested in a dedicated workforce planning team using a recognised safer staffing tool. This work had started in August 2017. All wards had been assessed to define and confirm safe staffing numbers, optimum staffing numbers and ward establishment numbers. The planning team had also assessed optimum therapeutic numbers for the multidisciplinary team.
- A qualified nurse was always present in communal areas of the ward.
- We saw in care records that there were enough staff so that patients had regular 1:1 time with their named nurse.
- Escorted leave or ward activities were rarely cancelled because there were too few staff.
- The hospital had a dedicated physical healthcare team consisting of a non-medical prescriber, a paramedic and healthcare assistants to ensure physical interventions were carried out safely.
- Doctors provided adequate medical cover day and night and would attend the ward quickly in an emergency.
- Overall, managers ensured that staff were up to date with appropriate mandatory training. The overall compliance rate for was 84%. However, fewer than 75% of staff on Speedwell ward had undertaken three specific elements of the training programme that the provider had deemed to be mandatory. These were information governance and information security (52% of staff had completed this), basic life support training and immediate life support training (72% and 70% of staff respectively). There was therefore a risk that staff may not be aware of best practice for handling sensitive information and a risk that should a patient require basic or immediate life support that not all staff would be aware of the most up to date training for such an event.

Assessing and managing risk to patients and staff

- There were 18 episodes of seclusion on Speedwell between 1 October 2017 and 31 March 2018. Over the same period there were 21 restraints for nine patients. One restraint was in the prone position.
- We examined seven care records on Speedwell ward, all but one record showed that staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident. There was one record for which the risk assessment had not been updated following every incident, however this patient was acutely unwell and there were incidents on a daily basis. As such this patient had been temporarily moved to another hospital due to the damage of the seclusion room meaning that they could not be safely cared for on Speedwell ward.
- Staff used the short-term assessment of risk and treatability screening tool, and the Historical Clinical Risk Management -20 tool, both tools are nationally recognised risk assessment tools.
- All patients being treated on Speedwell ward were detained under the Mental Health Act (1983).
- We observed good policies and procedures for observation were in place, including to minimise risk from ligature points and searching patients.
- The provider was focused on reducing restrictive practice. From the evidence we reviewed, we concluded that staff used restraint only after de-escalation has failed and using correct techniques, all permanent and regular bank staff were trained in the management of actual or potential aggression. The use of rapid tranquilisation was rare on Speedwell ward but when it was necessary staff followed National Institute for Health and Care Excellence guidance on administration of rapid tranquilisation medication.
- We saw in care records that seclusion was used appropriately and followed best practice. The records for seclusion were kept in an appropriate manner.

Track record on safety

- Speedwell ward reported eight serious incidents in last 12 months.
- The most common reason for serious incidents was patient violence and aggression and allegations about staff management of these. The provider responded by changing to management of actual and potential aggression training because they recognised that previous techniques for management of aggression and

violence was overly restrictive. They had re trained 100% of clinical staff across the hospital which, along with other initiatives, decreased the use of restrictive interventions.

Reporting incidents and learning from when things go wrong

- Staff told us they knew what to report and how to report. All incidents that should be reported were reported on an electronic database.
- Staff were open and transparent and explained to patients when things went wrong.
- Staff told us they received feedback from the investigation of incidents in their clinical area but were not aware of incidents external to the service. There was evidence of red top alert posters on wards highlighting current risk issues and discussion about serious incidents was evident in board level meeting minutes, however we noted that incidents were not routinely discussed at ward team meetings.
- Managers held daily morning meetings to discuss any serious incidents from overnight or the previous day. Actions from these meetings were disseminated to staff via email.

Managers debriefed staff and offered them support after serious incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed seven care and treatment records on Speedwell ward. All but one record demonstrated that staff followed good practice in terms of holistically assessing patients on admission. Staff had not completed appropriate care plans for one patient with complex needs and behavioural issues. We found there was no positive behavioural support plan for staff to follow and an inconsistent approach to assessment and care planning for this patient. Staff demonstrated a lack of understanding of the patient's needs.
- For the six other care records we examined we found that staff had completed comprehensive and timely assessments completed after admission, including a physical examination and personalised, holistic, recovery orientated care plans which were regularly updated.
- All information needed to deliver care was stored securely on electronic records and available to staff when they needed it, including when people moved between teams.

Best practice in treatment and care

- Of the seven care records that the team examined for this core service, staff demonstrated good practice in six. We saw evidence that staff followed National Institute for Health and Care Excellence guidance when prescribing medication.
- Staff offered recommended psychological therapies for post-traumatic stress, sex offender work, anger management and recognising emotions, fire setting work, and to support patients who self-harmed.
- A dedicated physical healthcare team provided good access to physical healthcare for patients. They offered structured appointments for patients as they would in the community. The physical healthcare team benchmarked their service in line with GP practices to provide screening programmes for chronic diseases, diabetes management, and triple aortic aneurism screening in older patients. Staff told us they would refer to specialists when needed, although said there had been difficulties referring into NHS services. The team leader for the physical healthcare team was working with commissioners to improve access to external services.
- We saw evidence in care records that staff assessed and met patients' nutrition and hydration needs.
- Staff used recognised rating scales to assess and record severity and outcomes such as the Health of the Nation Outcome Scale for secure services, the Beck Depression Inventory, the Beck Anxiety Inventory, the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM). Occupational therapists used the Vonda Du Toit Model of Creative Ability and the Model of Human Occupation. Lead occupational therapists were involved in the writing of latest research using these tools alongside local universities.
- Clinical staff participated actively in clinical audit of care records, we saw that care plans and positive

behavioural support plans were updated in line with these audits. The provider also conducted quarterly audits of clinic rooms and the electronic prescribing system.

Skilled staff to deliver care

- The provider had the full range of disciplines needed to deliver care including; nurses, occupational therapists, psychologists, teacher, social workers, healthcare assistants and activities coordinators. However, staff told us that there was reduced experienced occupational therapy presence in the multidisciplinary team because recent staff changes meant experienced staff had left and been replaced with newly qualified staff.
- We spoke with a number of recently qualified staff during inspection, they told us that they received an appropriate induction, and healthcare assistants told us that the Care Certificate standards were used as the benchmark for healthcare assistants' induction.
- Managers ensured that staff received regular supervision appraisal and had access to regular team meetings. All non-medical staff had received an appraisal in the last 12 months.
- The provider had a learning and development department providing staff access to the necessary specialist training for their roles. However, we spoke to three newly qualified staff who told us that it had been difficult to access training as the training was often facilitated at another of the provider's locations and had been cancelled frequently.
- We saw evidence in staff files that managers addressed poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- Staff participated in regular effective multi-disciplinary meetings.
- We observed effective handovers within teams. The manager had a dedicated handover template with key areas to be discussed for each patient at the start and end of each shift, including risks, behaviour, patient's presentation and a "positive message".
- Staff had effective working relationships with other teams and stakeholders. The provider told us about joint working with two local NHS trusts to support patients along the recovery pathway and out into the community. In addition to ensuring good handovers for patients who were moving on, the provider was linking up with other stakeholders to promote the work they do and create new joint pathways, such as community support which would be facilitated by all stakeholders.

Adherence to the Mental Health Act (1983) and the Mental Health Act (1983) Code of Practice

- The provider had a dedicated centralised Mental Health Act team including an administrator who examined Mental Health Act (1983) papers on admission. Staff knew who the administrators are and could get support to ensure that the Act is followed in relation to, for example, renewals, consent to treatment and appeals against detention.
- The provider developed a combined mandatory training module on The Mental Health Act (1983), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. The provider had a target of 21 staff on Speedwell ward to complete this training but only 14 (67%) staff had achieved this.
- We saw that staff adhered to consent to treatment and capacity requirements and copies of consent to treatment forms were attached to medication charts where applicable.
- Staff demonstrated in patient records that they explained patient's rights under the Mental Health Act to them on admission and routinely thereafter.
- Staff ensured detention paperwork was filled in correctly, was up to date and stored appropriately.
- Staff completed regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits.
- Staff ensured that patients had access to Independent Mental Health Advocate services. Staff were clear on how to access the advocacy service to support patients regarding capacity issues, or access to wards and records. Staff displayed posters with the names and contact details of the mental health advocacy services.

Good practice in applying the MCA

- Staff were trained in and had a good understanding of Mental Capacity Act (2005), the five statutory principles. The provider had a policy on the Mental Capacity Act (2005) including Deprivation of Liberty Safeguards which staff are aware of and can refer to on the intranet.
- Staff had completed capacity assessments for patients who might have impaired capacity., Staff had assessed and recorded capacity to consent appropriately. This

Good

Wards for people with learning disabilities or autism

was done on a decision-specific basis with regards to significant decisions. Staff assisted patients to make a specific decision for themselves before they were assumed to lack the mental capacity to do this.
- Staff made decisions for patients who lacked capacity, in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty Safeguards. At the time of inspection all patients in the hospital were detained under the Mental Health Act (1983) so no Deprivation of Liberty Safeguards applications had been made.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed positive staff attitudes and behaviours when interacting with patient's. Staff were responsive, discreet, respectful, and provided appropriate practical and emotional support.
- Patients told us that staff treated them well taking the time to listen to their concerns and were sensitive to their issues.
- Patients on Speedwell said they felt staff understood their individual needs but occasionally lacked staff to fulfil requests for leave. There was also a lack of admin support on the ward which meant patients had difficulty requesting financial information.

The involvement of people in the care they receive

- Staff ensured the admission process informed and orientated patients to the ward and the service. Staff displayed posters in communal areas alerting patients to the daily activities and meetings for the ward.
- Patients told us they were actively involved in care planning and risk assessment and this was evident in care plans.
- Patients had access to advocacy and there were posters displayed near the ward telephone giving details of how they could be contacted.
- Carers told us they felt involved in their relative's care. There was a visitors' suite near the hospital entrance and families could also use the café with their relative.
- Patients gave feedback on the service they received at weekly community meetings.
- Patients could be involved in decisions about the service and had been involved in the recruitment of staff.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

Access and discharge

- The average bed occupancy on Speedwell ward was over the last six months was 91.5%.
- Over the past 12 months there were no patients admitted whose home address was more than 50 miles away.
- There was no waiting list for beds on this ward.
- The provider did not admit new patients to beds which were occupied by patients on leave, ensuring patients always had access to a bed on return from leave.
- Staff did not move patients between wards during an admission episode unless this was justified on clinical grounds and in the interests of the patient. When patients were moved or discharged this happened at an appropriate time of day.
- In the last six months the provider reported no delayed discharges.
- Managers planned the services to integrate with other organisations and the local community and ensured that services met people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The provider had worked with local stakeholders to form a "Reach Out" group to look at local care provision, and establish recovery orientated discharge pathways. This enabled patients to continue using the skills they learnt in hospital, when discharged into the community.

- Care plans referred to identified section 117 aftercare services to be provided for those patients' subject to section 3 or equivalent Part 3 powers of the Mental Health Act (1983), authorising admission to hospital for treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider tailored services to meet the needs of individual patients and these were delivered in a way to ensure flexibility, choice and continuity of care. The provider had a full range of rooms and equipment to support treatment and care and help patients build skills to support them when they moved on from services. The provider had a range of activity and therapy rooms, including a library, music room with recording studio, information technology suite, therapy kitchen, art therapy room and was in the process of building an occupational therapy hub which would in time provide patients with skills of heavy and light industry such as woodwork.
- The provider ensured there were quiet areas on the wards where patients could have time to think or pray and staff supported patients to attend the multi faith centre near the hospital entrance. This included a wudoo (a wudoo is a sink) where patients could wash their hands and feet before prayer. There was also a visitors' suite where patients could meet with visitors.
- The hospital provided a physical healthcare suite in addition to clinic rooms on each ward. The physical healthcare team or GP would examine patients in the suite. Managers had commissioned the physical healthcare service in a way that mirrored healthcare services in the community enabling patients to make their own appointments outside of the ward environment. The service would refer on to more specialist services if required.
- Patients could make a telephone call in private. There was a telephone in a private room and some patients used mobile phones when on leave from the hospital.
- Patients had access to outside space, the ward had a garden and access to fresh air was unrestricted.
- Patients told us that food was of an acceptable quality, patients could choose meals from a weekly menu, purchase food from the onsite café, or if individually care planned could shop and cook in the therapy kitchen. Patients had access to hot drinks and snacks 24 hours a day, seven days a week and could order in take away food if they wished.
- The provider supported patients to personalise their bedrooms on all wards. Staff had individually risk assessed this to allow patients access to technology such as games consoles in their rooms, provided the patient consented to having their equipment appliance tested and internet access restricted.
- Patients could store most of their possessions in their rooms but there was also locked space provided for restricted items that were not permitted on the ward but could be used on leave from hospital.
- Staff provided activities for patients, including at weekends. Staff displayed activities planners were for patients to see on all wards.
- Staff put patient's s individual needs and preferences as central to the planning and delivery of the service. All patients were encouraged to identify their strengths and interests as part of the care planning process and care plans reflected this. We also saw an example where a patient with a special interest in music was able to write and record their own songs in the on site studio. Staff had supported the patient to share their music at community events and events within the hospital. Other patients had been supported with their interest in art to create a monument of a "bipolar bear" for a local community project.
- The provider told us that across the hospital 54% of patients were white British, 16% were black, 11% were Asian and 3% are white other. The provider monitored the ethnic profile of wards particularly related to language and religion as these can impact on the response to diagnosis and treatment.
- The provider demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. The provider used interpreters to ensure patients could communicate if they did not speak or understand English, they also worked with catering so that their cultural needs were met with respect to diet. The provider had a RACE (Race, Culture and Ethnicity) group who looked at ways that patients from different ethnic backgrounds could be supported. The chaplaincy department ran an awareness session on Ramadan and worked with catering on what foods to serve post fasting.

Good

Wards for people with learning disabilities or autism

- The provider had a representative proportion of black and ethnic minority staff and advocates that aligned with the patient population.
- Staff provided information in other languages and there were examples of wards buying in newspapers, CDs and books in different languages to enable patients to keep connected to their cultural identity. The chaplaincy department carried out an exercise to establish patient feedback on how the provider met their spiritual needs.
- Staff provided accessible information on treatments, local services, patients' rights, and how to complain.

Listening to and learning from concerns and complaints

- The provider actively reviewed complaints and involved patients and staff in how they were resolved and responded to, improvements were made as a result across the service. The provider reported that there were five complaints received in the 12 months from 1 April 2017 to 31 March 2018. Three of the complaints were upheld or partially upheld, none were referred to the ombudsman. Complaints that were upheld related to communication issues and were locally resolved. The service also received one compliment during the same period.
- Most patients knew how to complain and there was information detailing how to complain on all wards. Staff knew how to handle complaints appropriately. Complaints were investigated promptly and staff received feedback on the outcome of investigation of complaints and acted on the findings. There was evidence of this in team meeting minutes and care records.

Are wards for people with learning disabilities or autism well-led?

Good

Vision and values

- Staff knew and agreed with the organisation's vision: to transform lives together. The values which underpin the vision and the provider's strategy were; compassion: be supportive; understand and care for patients, their families and all in the community. Accountability: take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: innovate, learn and deliver; whatever you do, do it well.
- The provider was in the process of implementing a value-based healthcare approach aimed at providing the best patient outcomes for the best investment and involving the introduction of Integrated Practice Units to provide care to patients with similar clinical needs.
- Managers ensured that team objectives reflected the organisation's vision and values. Managers displayed their ward values on the walls in patient areas and patients had been involved in writing these values.
- Staff knew who the most senior managers in the organisation were and these managers visited the wards on a regular basis. The provider had made changes to the roles and responsibilities of staff in the senior management team and not all staff were aware of these changes.

Good governance

- Managers ensured that staff received mandatory training, were appraised annually and supervised monthly.
- Managers ensured that shifts were covered by enough staff of the right grades and experience, and staff maximised shift-time on direct care activities.
- Staff participated actively in clinical audits and patients were also involved in suggesting which aspects of care should be prioritised for audit.
- Staff reported incidents and managers ensured that staff learnt from incidents, complaints and service user feedback.
- Managers ensured that staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures.
- The provider used key performance indicators to gauge the performance of the team. One of the priorities was to train at least 90% of clinical and ward based staff in the use of MAPA. This was achieved with 100% of clinical staff having been trained across the hospital. Another priority was to reduce the use of restrictive interventions. The use of seclusion had fallen from 9.2 to 6.6 per 1000 occupied bed days and the use of prone restraint from 6.6 to 4.1 per 1000 occupied bed days over the course of the year. The provider attributed this in part to the Safewards model of managing conflict and

containment, but also the close monitoring by the senior management team and the scrutiny of the provider's restrictive practice monitoring group, which met monthly.
- Ward managers told us they had sufficient authority to do their job and staff had the ability to submit items to the charity's risk register.

Leadership, morale and staff engagement

- The provider reported an employee engagement score of 64% in their 2017 staff survey.
- Sickness and absence rates amongst permanent staff was 2.2% on Speedwell ward.
- The provider did not report any bullying and harassment cases, however, three staff told us they had been interviewed by senior managers, wanting to know what they had told CQC following their interviews as part of this inspection.
- Staff told us they knew how to use whistle-blowing process and felt able to raise concerns without fear of victimisation.
- The majority of staff spoke of having good morale, job satisfaction and sense of empowerment.
- Staff told us the provider had excellent resources for external staff support such as counselling services. Pastoral care for staff was also provided by the chaplaincy service.
- The provider offered opportunities for leadership development.
- Staff were open and transparent and explained to patients if something went wrong.
- Staff were offered the opportunity to give feedback on services and input into service development.

Commitment to quality improvement and innovation

- The provider is a member of the Quality Network for Forensic Mental Health Services and are reviewed annually by their peers. They are also accredited by The National Autistic Society.

Outstanding practice and areas for improvement

Outstanding practice

- The provider tailored services to meet the needs of individual people and delivered these in a way to ensure flexibility, choice and continuity of care. The provider had a full range of rooms and equipment to support treatment and care. The provider employed a full time teacher who worked across the hospital and linked up with local education providers to help patients build skills to support them when they moved on from services.
- A dedicated physical healthcare team ensured patients had good access to physical healthcare. The team structured appointments for patients as they would in the community. The physical healthcare team benchmarked their service in line with GP practices to provide screening programmes for chronic diseases.
- The provider demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. The provider used interpreters to ensure patients could communicate if they did not speak or understand English, they also worked with catering so that their cultural needs were met with respect to diet. The provider had a RACE (Race, Culture and Ethnicity) group who looked at ways that patients from different ethnic backgrounds could be supported. The chaplaincy department ran an awareness session on Ramadan and worked with catering on what foods to serve post fasting.
- Managers planned the services to integrate with other organisations and the local community and ensured that services meet people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- The provider was part of a "Reach Out" group with two local NHS Trusts the group aimed to look at service provision in the local area and to facilitate timely supported discharges for patients into the local community.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that medication is stored at the correct temperature.
- The provider must ensure that there is a suitable lock on the office door on Speedwell ward.
- The provider must ensure that referrals to specialist services for patients with serious health concerns are made in a timely manner

Action the provider SHOULD take to improve

- The provider should ensure that damage to the environment is repaired promptly.
- The provider should ensure that the temperature of locked wards is comfortable for patients.
- The provider should ensure that all patients have positive behaviour support plans.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safe care and treatment. On Hurst ward and in the separate physical healthcare clinic room the ambient room temperature was 29.8 degrees centigrade. In the months of May and June 2018 the provider had recorded temperatures above the maximum 25 degrees centigrade from 5 May 2018, yet had continued to dispense medication from these rooms. There was a risk that medication may become less effective if stored at the incorrect temperature. The lock to the staff office door on Speedwell ward had been damaged meaning that staff had to use a key to lock the door. There was a risk that staff may forget to lock the door as they entered or left the office, leaving patients able to access confidential information, or that it would take staff longer to respond to incidents due to having to unlock the door. On Lifford and Edgbaston wards there was a delay in referrals to urology for two patients who had markers indicating they could have prostate cancer. This meant that there was a risk of a delay in diagnosing a potentially treatable cancer. This was a breach of regulation 12