CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Thursday 25 November 2021 at 9.30 am

Microsoft Teams and Conference Room, Main Building
St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG

		Info / Dec	LEAD		Page No.	Timing
1.	Welcome and Apologies	Information	Paul Burstow		*3*	*9.30*
Administration						
2.	Declarations of Interest	Information	Paul Burstow		*4*	*09.31*
3.	Minutes from the Meeting in Public Board of Directors Meeting on 30 September 2021	Decision	Paul Burstow	✓	*5-12*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*13-16*	*09.35*
Chair's Update						
5.	Chair Update	Information	Paul Burstow		*17*	*09.40*
Executive Update						
6.	CEO Report	Information	Jess Lievesley	✓	*18-23*	*09.45*
Governance						
7.	Court, Board of Directors and Committee Calendar and Board of Directors Annual Work Plan	Decision	Duncan Long	✓	*24-33*	*09.55*
8.	Governance Oversight Group update and Terms of Reference approval	Assurance & Decision	Alex Owen (Sally McIntyre)	✓	*34-37*	*10.05*
Assurance						
9.	**Committee Updates**				*38*	*10.15*
	• Pension Trustees	Information	Martin Kersey	✓	*39*	
	• Audit & Risk Committee	Information	Elena Lokteva	✓	*40-42*	
	• Quality & Safety Committee, incorporating IPC Annual Report	Information & Decision	David Sallah	✓	*43-62*	
	• People Committee	Information	Paul Burstow	✓	*63-67*	
	• Nominations & Remuneration Committee, incorporating Gender and Ethnicity Pay Reports	Information & Decision	Stuart Richmond-Watson	✓	*68-72*	
Operations						
10.	Integrated Quality & Performance Report, incorporating: • Divisional Performance • Finance update • Covid response and update • Information Security Metrics	Review & Comment	John Clarke, Alex Owen & Dr Sanjith Kamath	✓	*73-101*	*10.40*

11.	Estates and Facilities Annual Board Update	Information	Alex Trigg	✓	*102-104*	*10.55*
Break 11.05 am - 11.15 am						
Quality						
12.	CQC Inspection Reports – Men's and Women's Services *(Annexes – pages 140 – 327)*	Information	Andy Brogan	✓	*105-106*	*11.15*
13.	Education Update	Information	Martin Kersey (Dr P. McAllister, Dr D. Morris & Cheryl Smith)	✓	*107-122*	*11.25*
Matters Arising / Discussion Topic						
14.	Trauma Presentation	Information	Martin Kersey (Dr Deborah Morris)	✓	*123-135*	*11.40*
Patient / Carer Voice						
15.	Divisional Presentation (including patient voice): Locked and Specialist Rehab (LSSR) Division	Information	Dr Sanjith Kamath *(Dr Elizabeth Beber and Patient)*	✓	*136*	*12.10*
Any Other Business						
16.	Questions from the Public for the Board	Information	Paul Burstow		*137*	*12.40*
17.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*138*	*12.44*
18.	Date of Next Meeting - Thursday 27 January 2022	Information	Paul Burstow		*139*	*12.45*
Meeting Closes at 12.45 pm						

Welcome and Apologies

(Paul Burstow – Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 30 September 2021

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

Microsoft Teams Meeting and Meeting Room 9, William Wake House, St Andrew's Healthcare, Northampton

Thursday 30 September 2021 at 09.00 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Katie Fisher (KF)	Chief Executive Officer
Jess Lievesley (JL)	Deputy Chief Executive Officer
Alex Owen (AO)	Chief Finance Officer
Andy Brogan (AB)	Chief Nurse
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Executive HR Director
In Attendance:	
John Clarke (JC)	Chief Information Officer
Duncan Long (DL)	Company Secretary
Dr Alex Hamilton (AH) Item 1	Clinical Director
Eddie Short (ES) Item 8	Head of Strategic Partnerships
Michaela Roberts (MR) Item 14	Senior Programme Manager
Dr Ash Roychowdhury (AR) Item 14	Deputy Medical Director
Melanie Duncan (Minutes)	Board Secretary
Apologies Received:	
David Sallah (DS)	Non-Executive Director

Agenda Item No		Owner	Deadline
1.	**Welcome** PB (Chair) welcomed everyone to the first part of the Board of Directors (Board) meeting, which is a meeting held in public, and noted the apologies received.		
DIVISIONAL UPDATE			
2.	**Divisional Presentation (including Patient Voice): 23a The Avenue (Deaf Service)** JL introduced AH and the patient from the Division. JL explained that the provision of care had been developed over a period of time and had been designed to facilitate the patient's move from secure care to a community setting. AH introduced himself and the patient, and explained the location, and the process that the patient had gone through from the original ward setting to the current location, where the patient had lived for six months. The patient was communicating via sign language which an interpreter then translated for the Board. AH and the patient gave a brief summary of how long the patient had been in hospital, noting that the past 10 years had been with St Andrew's. The difference between ward living and living within the house was noted, with the		

	patient highlighting that the house was preferred as it was quieter with fewer staff, coupled with greater independence and the ability to visit family; access to the internet and a mobile phone were also considered to be plus points. PB introduced himself and asked if there was anything else that would be helpful to the patient that would ease the transition to more independence. The patient responded, to move back to Cornwall to be near to family was the long term aim. AH further explained that the house had always been seen as a stepping stone, and that the goal was to build independence, so that the patient could move to an independent flat in Northampton within reach from St. Andrew's and then a move home after approximately 6 months could be effected. JL was delighted to hear about the progress made, and extended thanks for the patience shown whilst the house was being set up. KF asked if there was anything that could be shared in order to make others' experience better. The patient replied that a quicker process for moving into the house would be better. PB thanked the patient for the time afforded, and wished best wishes for the future.		
ADMINISTRATION			
3.	**Declarations Of Interest** All members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting that they are required by s.177 of the Companies Act 2006 and the Charity's Articles of Association to disclose.		
4.	**Minutes Of The Board Of Directors Meeting, held in public, on 24 August 2021** The minutes of the meeting held on the 24 August 2021 were **AGREED** as an accurate reflection of the discussion, subject to the agreed revisions within item 2, Divisional Presentation.	**DECISION**	
5.	**Action Log & Matters Arising** 26.11.20 **01 –** Board Seminars **-** Ongoing 28.01.21 **06 –** Community Services **–** Further sessions are included within the 2022-23 Annual Board Plan and Board Strategy discussions. 27.05.21 **01 –** East Midlands Alliance - Ongoing 27.05.21 **02** – NHS Benchmarking Network - Ongoing 27.05.21 **04** – Data Security – Performance Report – Initial report included within agenda and metrics to be included in future Board Performance Reports. Action **CLOSED** 24.08.21 **01** – Lessons Learned and Transformation Programme update - Ongoing 24.08.21 **02 –** Integrated Performance Report – Quality **-** Has been included and will be presented to Board in November – Action **CLOSED** 24.08.21 **03** – Integrated Performance Report – Training Budget **–** Ongoing. 24.08.21 **04** – Staffing Action Plan – Outcomes - Ongoing 24.08.21 **05** – Safe Staffing Report - Committee Oversight **-** Ongoing	**DECISION** **DECISION**	

	24.08.21 **06** – Armed Forces Covenant – People Committee Veterans Report - Ongoing 24.08.21 **07 –** Quality & Safety Committee – Community Partnership Update - SK update that the clinical records had now been addressed. Action **CLOSED**.	**DECISION**	
CHAIR'S UPDATE			
6.	**Chair Update** PB gave a verbal update and outlined his visits to both Birmingham and Essex, noting the differences with Northampton. PB had enjoyed a number of one to one conversations and a group discussion with Governors, with a joint Board and Governor session planned for the 15th October in order to discuss progress and development. PB had also met with the Chairs of the East Midlands Mental Health Providers regarding governance of the provider alliance and the level of formality of the partnership. The Board **NOTED** the update.		
EXECUTIVE UPDATE			
7.	**CEO's Report** KF gave a verbal update and apologised for the lack of a written report. KF updated that there had been an unannounced CQC visit to Winslow, with the report already having been received, and the expectation that further wards would be inspected in the near future. No formal CQC report had been issued with regard to Northampton. KF noted the recent fuel challenges, commenting that there was good contingency planning with no disruption to the Charity. Staffing remained a challenge, both in the Charity and across the whole healthcare sector. KF wished to note that this is was not the case across all of the Charity's sites or shifts, and that it was being overseen and monitored with close management. KF also notified the board that the NHS planning guidance was to be sent that week, which was key from a funding perspective. Further Board Development sessions had been planned with the East Midlands Alliance and KF encouraged everyone to attend at least one session. The vaccination booster programme was due to commence on the 4th October, with plans to roll out the Flu vaccine at the same time. EL asked if there would be more staff pressures as winter approached. KF replied that it would be difficult to comment within this year, as we were already at high absence rates as a result of Covid and D&V. NHSE had said that there could be a greater incidence of upper respiratory illnesses this winter. KF noted that maximising recruitment and retention would be undertaken in order to support this. JL reiterated KF's comments and noted there could be a short-term impact on staff, and contingencies were being worked on. The focus had to be on the existing workforce and support for them. AB added that it was hoped that the uptake for the flu vaccine would be increased as a result of the Covid booster. The Board **NOTED** the update		
8.	**St Andrew's Healthcare 2021 – 2026 Strategy** PB introduced the session, highlighting that a more detailed discussion would be held in Part Two of the Board meeting.		

	JL presented an outline of the Charity's Strategy and noted the attendance of ES within the meeting. He explained that this document showed the basis on which the Charity wanted to work and prioritise in the coming years. The phasing matrix showed how the work would be approached between now and 2026, with each Executive owning an area of the strategy. JL was seeking Board support for the direction of the main Strategic themes, following which the strategy would be further unpicked with business cases and assessments of any investment need, being brought to Board to further develop the priorities. Each of the seven Strategic areas has an Executive responsible for them who will provide further detail throughout the discussions. JL further outlined what the Board needed to consider with regard to delivery of the strategy, and how oversight and strategic risk management would be done via the Board Assurance Framework (BAF). PB added that a full Board discussion would be had in Part Two, at which point DS would be able to join the meeting. The Board **NOTED** the report		
GOVERNANCE			
9.	**Ernst & Young Governance Review Report & Implementation** PB outlined the process and timelines that the review had undertaken, and that the full report from E&Y had been included within the pack. He explained the challenges that this report highlighted and that a new Governance Oversight Group will be formed to oversee the implementation of the actions within the report and to debate the actions being undertaken. The Group will also look at ensuring the right support is provided to assist in the development of the Board and the Governors, as well as maintaining consistency across the committees and governance documentation. PB asked for expressions of interest for inclusion within the Governance Oversight Group, and thanked those who had already responded, noting that NED involvement would be required. PB re-iterated that the new Governance arrangements would be co-designed and part of this was the holding of joint meetings with the Court and Board, as being done on the 15th October. The Board discussed the timelines involved in the implementation along with maintaining synergy with the Charity's Strategic signposts, with concerns being voiced regarding the amount of work being considered at the same time and that the correct level of resource is given to the programme of works. It was agreed that the most urgent areas would be addressed first to ensure they did not hinder the development and implementation of the Strategy. PB added that the Board recognised that the implementation of the recommendations will require a dedicated resource and programme of works and a balanced approach to implementing the changes. The Board would ensure the overlaps between the changes required for the Strategy and for Governance were brought together and managed. The Board was responsible for ensuring the governance and strategic activities were effectively integrated. The Board **NOTED** the report and **AGREED** to the recommendations.	**DECISION**	
10.	**Emergency Preparedness, Resilience and Response (EPRR) Submission** JL outlined the report, which was taken as read and noted that under normal circumstances the paper would have been considered by the Audit and Risk Committee (ARC) first, however, due to the reporting timelines being brought forward by the commissioners, the paper required consideration by the Board prior to submission. The submission will be provided retrospectively to ARC.		

	The Board discussed the level of compliance, noting that the Charity was reporting as substantially compliant. JL highlighted two outstanding areas. The first was the requirement for a NED to be an EPRR representative. The second relates to mutual aid across the system. JL asked if EL, as Chair of ARC, would consider the NED EPRR role. EL accepted the role. JL outlined that the Charity is actively engaged with system partners and that all partners would be reporting that there was further work required in this area. The level of existing provision was discussed (including post Covid), prior to the requirement to report under the framework, with assurance being given that the Charity benefited from excellent working relationships with the other organisations locally, and submitted to regular testing both on an operational and support services basis. Covid had to a degree pressure tested the systems and has informed the thinking and responses within the submission, as well as bring those within the system much closer together. Further discussions centred on the Charity's planning for emergency preparedness and the risks that the Charity faces, with multiple building failure (within Northampton) seen as the most significant of risks. This would require a system wide response, whereas measures are in place to effectively manage single building failures. The Board **APPROVED** the report for submission to NHSE	**DECISION**	
ASSURANCE			
11.	**Committee Updates** **People Committee** PB gave the highlights from the update, and noted that outcomes from the committee would be reported in due course. The following report and strategies were all **APPROVED** by the Board: *Diversity and Inclusion Annual Report* *People Strategy* *Diversity and Inclusion Strategy* **Quality & Safety Committee** SN presented the highlights from the update. The update confirmed a number of reports that had been brought to the committee and were being presented for Board's attention and approval. *Complaints Annual Report* - Learnings from complaints was discussed along with the measures being undertaken in order to ensure that this is done in a timely manner, and the relevant Committees that would need to be involved as a result. PB requested that all complaint themes be visible at the Quality and Safety Committee, and that the outcomes of HCA assessment centres be discussed at People Committee. The Board **APPROVED** the Complaints report *Safeguarding Annual Report* - AB clarified the timelines covered by the report, and that changes noted had already been implemented. Training was still a challenge, with the numbers that were required to attend Level 4 being increased. Some of Level 3 would be delivered face to face following the lifting of restrictions. JL noted that transparency around reporting was now much better, and acknowledged that this area was a challenge and clinical judgement to be	**DECISION** **DECISION**	

	used. PB noted that it would of benefit to the Board to look at this area in greater depth. The Board **APPROVED** the Safeguarding report *Nursing Strategy* – AB presented and highlighted the 4 key areas of the strategy, which were based on basic, fundamental high quality nursing care. The financial aspects of the strategy were discussed with clarification being given as to where the budget was located for this work, together with where this strategy would sit in the Charity-wide strategy. The target outcomes were noted. The Board **APPROVED** the Nursing Strategy	**DECISION** **DECISION**	
OPERATIONS			
12.	**Board Performance Report** JC presented the report which was taken as read, and noted that many of the topics had been discussed during the meeting and at other committees. JC also noted that the Covid section included data from the differing waves that indicates the impacts of lessons learned and vaccines on the data. AO presented the financial aspects of the report outlining the challenges that the restrictions on occupancy had had on the reported numbers and the actual deficit incurred. The increase in trade debtors was discussed with AO explaining that this is an increase that is regularly seen at that time of year, which reduces over the second half of the year and relates to the agreed fees increase applied in April. It is regularly reviewed within Finance and at FinCom. SN reiterated his request to have rolling averages in regards to some of the targets, and how this would impact on the reported variances. JC agreed to liaise with SN to establish where changes to how and what is reported could be incorporated to bring this issue to a conclusion, including the metrics and thresholds applied. This would be addressed before the next Board meeting in November. Staff turnover, recruitment, sickness and planning were discussed with agreement that these topics should remain high on the Board agenda. The Board noted that deployment of staff would be key in the coming year, as recruitment would remain a challenge. MK confirmed that it would take time to see a reversal in some of the trends being seen as we move post Covid. JL responded that the two biggest priorities for him as he assumed operations responsibility was quality and staff morale, with staff retention a key focus. Being able to demonstrate the impact of these priorities is key and will be taken into account with improvements in the reporting. It was agreed that staffing forecasts (and anticipated trajectory for reported staffing metrics) would be included in the report, with PB asking JC to consider this item and liaise with RB with regard to the development of the area, taking into account RB's points on timescales, length of reporting and seeing a "tailored to issues" way of reporting. The Board **NOTED** the report.	**JC** **JC**	**25.11.21** **25.11.21**
13.	**Information Security Metrics** JC presented the new report and highlighted the information covered by the slides, and explained that he anticipated the core information from the report being condensed and integrated within the performance report for the November Board. Consideration should also be given to introduce an appropriate RAG rating to the metrics to aid Board's understanding and aid highlighting the main areas of concern.		

	The Board enquired regarding the assurances in place to ensure that information security is maintained and tested. JC ensured that this was being undertaken and that this underpinned the training provided. Further questions were raised in relation to learning from the March Phishing attack and JC confirmed that those areas recognised as greatest risk (such as Finance, HR and IT) have moved across to Multifactorial Authentication (MFA). This will spread throughout the Charity over this year. JC also detailed how we were assisted by our Information Security contractors and our main IT Supplier and how they continue to provide support in these areas. The Board **NOTED** the report.		
QUALITY			
14.	**Continuous Quality Improvement Awareness Session** SK introduced the session and outlined how the Charity uses CQI and the principles behind it and how it continued to be integrated within the clinical services. MR and AR shared slides which related to developing a culture of CQI, and outlined what part it played within total quality management, and its part in the vision of future quality. Discussions were had on CQI priorities and aligning them with BAU priorities and how CQI needs to be centrally coordinated. MR asked the Board to endorse a Board awareness session that would be facilitated by the St Andrew's team and NHFT. The Board **AGREED** to a future awareness session	**DECISION**	
ANY OTHER BUSINESS			
15.	**Questions from the Public for the Board** No questions were received for the Board.		
16.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other Business notified.		
17.	**Date of Next Meeting :** Board of Directors, Meeting in Public – 25 November 2021		

Approved – 25 November 2021

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

St Andrew's Healthcare Board of Directors MEETING IN PUBLIC Session Action List:

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
26.11.20 **01**	**Board Seminars** PB advised that he will explore the role of Board seminars as a means by which the Board can regularly discuss the strategic aspects of the Charity's work. PB will look to schedule these into the annual cycle of meetings in the New Year.	PB	25.03.21	**Closed**	**Ongoing** - The role of seminars will be considered in the light of the governance review. Additional dates are being added to calendars for future board strategy sessions. **25.11.21:** As agreed in September Board, all open actions relating to governance activities have been consolidated into a summary action log to be incorporated into the Governance Review project. The summary log is due to be discussed with the Programme Director at the next project review meeting. **Propose action is closed**
28.01.21 **06**	**Community Services** Following discussions on the CTS service the Board requested to have more information about the community services and for this to form part of the Board development sessions or the working plan, which will assist the Board in shaping a programme that will genuinely reflect and balance what we do.	JL & DL	27.05.21	Open	**Ongoing:** Community Services are reviewing their portfolio and future development plans. An opportunity to share the more detailed work of the service will take place at the September 2021 and March 2022 Board meetings, along with the plans for the expansion of the service in line with current strategic priorities. This is factored into the Board forward agenda and dates are being agreed between the CoSec and service**.**

27.05.21 **01**	**East Midlands Alliance** EL noted that it was good to see St Andrew's in the same forum with NHS providers and wondered if it would be beneficial to have a workshop for Board members in order to know more about partners. KF replied that she would be happy to support this. JL agreed that he would be happy to do a wider oversight of the different partners. JL took the ACTION to organise this session with PB and DL.	JL	30.09.21	Open	**Ongoing:** Workshops now underway across the alliance and single paper setting out the salient details of each partner is also in development.
27.05.21 **02**	**NHS Benchmarking Network** NHS Benchmarking have offered to present to QSC (and Board if required). PB noted the timescales involved and suggested a Board seminar session to look at the results so that we can spend more time than in a normal Board meeting. AB suggested that the timescales could be closer to the end of the year.	DL	25.11.21	Open	**Ongoing:**
24.08.21 **01**	**Lessons Learned and Transformation Programme update** (merger of actions 28.01.21 **01** and 25.03.21 **02**) Following the Mansfield closure and relocation of patients the Board is seeking assurance that lessons are learned across the Charity and lines of sight on this are to be maintained by the Quality Safety Committee (QSC) for future reporting to the Board. In addition, review and measurement of the impact of the Transformation Programme, based upon what is aimed to be achieved, is to be considered by the Quality & Safety Committee.	DS/AB & JL	25.11.21	Open	**Ongoing:**
24.08.21 **03**	**Integrated Performance Report – Training budgets** MK confirmed that he had a training budget breakdown which could be shared with the Board. PB asked for a paper on the charity's training budget and how the impact of training was assessed to be submitted to the People Committee for consideration.	MK	30.09.21	**Closed**	**25.11.21** An update was given by Holly Taylor, Director of L&D to the People Committee on L&D Spend and effectiveness at their last meeting **Propose action is closed**
24.08.21 **04**	**Staffing action plan - Outcomes** AL asked if the actual outcomes could be recorded alongside the actions and proposed outcomes on the new Staffing Action Plan. RB also requested a communications line be added to the action plan	JL	25.11.21	**Closed**	**25.11.21**: This has been agreed and formed part of the plan that was presented to People Committee. **Propose action is closed**

24.08.21 **05**	**Safe Staffing Report – Committee oversight** It was agreed that the new Safe Staffing report would be presented to both the Quality & Safety Committee and the People Committee for reporting, progress and assurance purposes ahead of submission to the Board.	AB	25.11.21	Open	**25.11.21:** Staffing report presented to latest People Committee and adapted report to be considered at QSC
24.08.21 **06**	**Armed Forces Covenant – People Committee Veterans Report** It was agreed that People Committee would receive a report from MK regarding veterans with the Charity's workforce.	MK	25.11.21	Open	**25.11.21:** A veterans update will be added to the People Committee Agenda for February
30.09.21 **01**	**Board Performance Report – Targets and metrics** JC agreed to liaise with SN to establish where changes to how and what is reported could be incorporated to bring this issue to a conclusion, including the metrics and thresholds applied. This would be addressed before the next Board meeting in November.	JC	25.11.21	**Closed**	**25.11.21:** Conversations have taken place with non-execs to help shape the requirements going forward. A plan for the ongoing development of the performance reporting agenda has been developed. **Propose action is closed**
30.09.21 **02**	**Board Performance Report – Staffing Forecasts** It was agreed that staffing forecasts (and anticipated trajectory for reported staffing metrics) would be included in the report, with JC to consider this item and liaise with RB with regard to the development of the area, taking into account timescales, length of reporting and seeing a "tailored to issues" way of reporting.	JC	25.11.21	Open	**25.11.21:** Staffing forecasts have been considered and will be brought in as part of the performance management of the new models rather than create something on the existing, but soon to be replaced, Hurst model.

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors	
Topic	CEO Board Update
Date of meeting	Thursday, 25 November 2021
Agenda item	**6**
Author	Jess Lievesley
Responsible Executive	Jess Lievesley
Discussed at previous Board meeting	Updates have been discussed at the Charity Executive Committee meetings
Patient and carer involvement	A number of these items would have been discussed with patients, carers
Staff involvement	
Report purpose	Review and comment ☐ Information ☒ Decision or Approval ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☒ Buildings and Information ☒ Innovation and Research ☒
Committee meetings where this item has been considered	

Report summary and key points to note

The attached is the Chief Executive's report to the Board of Directors from the Charity Executive Committee (CEC) meetings.

Appendices

CEO Report

This is the CEO report to the Board of Directors to provide information and assurance on the key areas of focus for the Charity Executive Committee over the last reporting period that are not dealt with under other agenda items for the Board.

1. Quality and patient experience

Patient Reported Experience Measures (PREMs)
The PREMs Framework is up and running, albeit we need to increase the engagement of our service users, wards and teams in this work. Accordingly each division is now undertaking an assessment to establish what methods of completing PREMs that are appropriate for their patient group so the implementation can be accelerated- this will include service user involvement to improve their understanding and engagement in the approach, including feedback on the most effective ways to implement the program.

2. East Midlands Alliance

The East Midlands Mental Health & Learning Disability Alliance has been a significant aspect of our quality improvement program and the work we are undertaking with Northampton Healthcare NHS Foundation Trust (NHFT) in response to the recent CQC inspection findings & related quality concerns. All partners are leading on different aspects of this work, led by NHFT and we are ensuring the internal and external reporting and assurance aspects of this work are fully aligned through our Quality & Safety Committee.

More broadly the alliance has held a series of well received seminars attended by members of all six of the respective organisational Boards, looking at areas of alignment and system wider service development.

3. CQC Men's and Women's Inspection, planning for neuro and update on CQC registration.

Following the CQC inspection of the Northampton Women's and Men's services in July, As the Board is aware and will be considered under a number of agenda items within the Board meeting, the Charity's Men's and Women's services have been rated Requires Improvement and Inadequate respectively and for the Women's service this represents the second consecutive Inadequate inspection. This is not an acceptable position for the Charity and a comprehensive quality improvement program is underway, delivered in partnership with members of the East Midlands Alliance and led by Northamptonshire NHS Foundation Trust.

On behalf of the Board and the Charity I have apologised to our service users and their carers for any failings of care that have taken place as well as committing to make significant improvements that will address the areas identified.

The CQC rightly highlighted a number of very positive areas of practice they observed however, understandably the attention within the report was drawn toward some of the bigger challenges and difficulties, with much of these emanating from our continued challenges with staffing, something that undoubtedly continues to be compounded by the pandemic.

As well as supporting the Women's service for their re-inspection within the required six month period of publication of the report, work is also being undertaken to support the Neuro Division and Community Partnerships with preparation for the expected inspections to their services.

4. Staffing – MHOST, workforce transformation

MHOST (Mental Health Optimum Staffing Tool)

The MHOST tool is a nationally recognised Safer Staffing Tool and widely utilised across our sector.

Using this tool, all wards will have a revised staffing model agreed with them to reflect their needs and the anticipated level of clinical acuity and need.

The Safer Staffing Matron is 'buddying' with their colleague in NHFT to gain insights and look at the correct policies and procedures ready for implementation.

The commencement of our implementation of MHOST will be January 2022, subject to agreement and will be reviewed every 6 months plus an annual review with recommendations to the Board.

Allocate

To support our implementation of MHOST the Charity will implement an e-rostering system used across the NHS, called Allocate. This brings with it a myriad of benefits to support the effective utilisation of our workforce- ensuring that we have the best possible deployment of colleagues across the Charity 24/7. Critically Allocate will also support a wider range of flexible working options for colleagues and will enable us to implement as a second stage, the safe care module that will provide us with close to real time ward acuity data across the Charity.

5. Strategy implementation

Following the signoff by the Board of the renewed Charity Strategy at the end of September, our attention has moved from the 'development' phase to the 'adoption' phase of the strategy lifecycle.

Our focus is attuned to the three priorities highlighted in the phasing plan for 21/22: Quality, Workforce Resilience & Agility and Finance & Sustainability. The key piece of work that spans all three of these areas is the work on the implementation of the MHOST workforce model and the Allocate scheduling solution.

Alongside these areas, we are progressing our Service Innovation priority: We have signalled our intent in relation to the future provision of services for people with learning disabilities and autism as being community based and are developing outline options for

progressing these ambitions. We are also commencing the work to establish the Business Development Team that will provide the initial capacity and capability to move service innovation forward.

The work of wider strategy adoption throughout the Charity is underway, commencing with our recent leadership event. A programme of strategy awareness sessions is in train which will be underpinned through an engagement and planning approach supporting the strategy 'ownership' through the Charity.

6. Leadership changes

The Board will be aware that Katie Fisher resigned her post on the 15th October and that I was appointed as Interim Chief Executive pending the appointment of a substantive CEO for the Charity.

To support the changes to my role and to ensure sufficient capacity is in place to maintain momentum in the quality improvement program and delivery of the wider strategic objectives of the Charity, I have asked Sanjith Kamath to take executive responsibility for Operations as Deputy CEO. I have also made two further non Board level director positions with Nikki May taking on the new role of Director of Care Delivery and Employee Experience and Edward Short taking on the Role of Director of Strategy. These colleagues will report to Sanjith and Alex Owen respectively who will hold the Board level responsibility for their portfolios.

These additions recognise both the need to ensure we maintain our oversight and grip on the delivery of our new strategy as well as recognising the importance of our employees' experience of working with the Charity as a primary driver to improving quality and improving the effectiveness of the care we provide.

7. ICS/Local System

The Northamptonshire Health and Care Partnership (NHCP) was formally given ICS designation in April 2021. St. Andrew's are engaged in two of the four ICS priority areas: the older adults iCAN (Integrated Care Across Northamptonshire) and Mental Health Workstreams.

In respect of the former we have been contributing to the ageing well ambition and inputting our expertise to help shape pathways and models including the community ageing pathway and dementia hubs. For the latter we are a partner within the Mental Health Collaborative Northamptonshire (MHC-N) steering group and members of relevant sub-groups.

Alongside this we have re-set our engagement with the Health & Wellbeing Forum and are exploring how we can contribute to this agenda and support our aims in relation to our 'anchor institution' standing in the town.

Our involvement in the various fora gives the Charity a visible presence within the local mental health system, an opportunity to demonstrate our leadership around key agendas and gives exposure to organisations that we have historically had little or no engagement with, but who may be vital to our ambitions in more community focussed services.

Our engagement to date has enabled opportunities with Northamptonshire Healthcare NHS Foundation Trust in relation to their participation in our non-medical responsible clinician programme and the exploration of collaborative opportunities around peer support worker and recovery college programmes. Additionally, the foundations of a deeper, system wide, collaboration around current and future workforce are being laid within the MHC-N.

8. Communications

Your Voice

The next Your Voice survey has just gone live, seeking to collect open and honest views from staff about working for St Andrew's. In the run up to launch we have been sharing details of the changes that have been brought about by previous surveys, to demonstrate that Your Voice is an effective way to be heard. These 'You said, we did' updates have focused on each division in turn. The survey will run until 6 December with results shared in the New Year.

Long service event

In September we held a long service event to celebrate members of staff who have given decades of their working lives to St Andrew's, and to our patients. The attendees - some of whom have worked for the Charity for over 30 years – all received a certificate and badge, and enjoyed cakes made by Workbridge. Due to the Covid pandemic it was different to the large, catered event we usually hold, but it was our safe way of saying thank you to staff for their long term commitment to our Charity.

CARE Awards 2021

We were delighted to be able to hold our Annual Awards presentation to celebrate our colleagues who live and breathe our Charity values. The winners were:

- Compassion - Mick Cooke, Healthcare Assistant, Low Secure and Specialist Rehab
- Accountability - Mounya Tarhouch, Healthcare Assistant, ASD/LD
- Respect - Pat Hart, Volunteer
- Excellence - Estelle Randall, Trainee Essential Skills Facilitator, Enabling Functions
- Volunteer of the Year - Chris Yates
- COVID Outstanding Contribution Award - the Education and IT teams

Lightbulb Launch

We shared the news of the very successful trial of the Lightbulb Mental Health Programme for schools led by Cheryl Smith, resulting in an article in the Northampton Chronicle & Echo.

Northampton Chronicle & Echo – New Column

Our local newspaper, the Chronicle and Echo, has asked St Andrew's to publish a column every month. Psychotherapist Liz Ritchie will draft a monthly piece about various mental health issues which may be affecting readers and people at home. Her first column appeared in September and focused on children's feelings about returning to school. The second edition, published in October looks at Seasonal Affective Disorder.

I'm Not Mad Me in the news

Kayleigh, one of three patients who starred in the St Andrew's I'm Not Mad, I'm Me documentary, had her story published on one of the country's leading news websites. FEMAIL, the female supplement for MailOnline, wrote an article about Kayleigh's recovery and how she was now preparing to leave the Northampton hospital and apply to catering college. ITV Anglia also covered the story and filmed with Kayleigh to find out more about her story.

Paper for Board of Directors

Topic	Court, Board of Directors and Committee Calendar and Board of Directors Annual Work Plan
Date of meeting	Thursday, 25 November 2021
Agenda item	**07**
Author	Duncan Long, Company Secretary
Responsible Executive	Paul Burstow, Charity Chair
Discussed at previous Board meeting	Annual Paper, discussed at previous Boards
Patient and carer involvement	Not appropriate in this instance
Staff involvement	Discussed with responsible executives and senior management, as well as Committee Chairs and Executive Assistants.
Report purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Not applicable

Report summary and key points to note

The attached committee calendar (appendix 1) covers the period of January 2022 to March 2023 and proposes dates to schedule the following meetings:

- Court of Governors
- Board of Directors & Board of Directors Strategy and Development days
- Nomination and Remuneration Committee
- Finance Committee
- Audit and Risk Committee
- Quality and Safety Committee
- People Committee
- Research Committee
- Pension Trustees
- Investment Committee

The proposed dates have been scheduled following discussions with the committee chairs, Executive Assistants and responsible executives and senior management. Many follow the existing frequency and scheduling and align with the committees current annual work plans. A number of additional meetings have been scheduled to account for reporting requirements that have historically fallen outside of the agreed meeting frequencies and previous schedules. Points to note:

Court of Governors

- Continue on a quarterly basis
- Additional joint development days with Board added throughout the year
- October AGM scheduled in-line with planned reporting for 2021-2022 financial year.

Board of Directors

- Continue on a bi-monthly basis
- Additional focussed meeting for Quality Account in-line with expected production timeline and required submission date
- Joint Court and Board development days scheduled, in addition to planned NHS Provider sessions and stand-alone board development and strategy days

Finance Committee

- Scheduled in-line with proposed fiscal reporting, accounting for budget, forecast and yearend processes. Continue as bi-monthly

People Committee

- Scheduled in-line with current timetable

Audit & Risk Committee

- Scheduled in-line with agreed ARC work plan and proposed fiscal reporting. Aligns with annual report review and approval

Quality & Safety Committee

- Scheduled in-line with agreed QSC work plan. Aligns with Quality Account report review and approval

Pension Trustees

- Further scheduling is being worked on to better align the meetings to financial reporting timelines. As a consequence the timings of the July and September meetings are being revised and discussed and may be subject to change (bringing them forward to closer align with month end financial reports).

The proposed schedule is based on the existing committee structure and will need to be further considered as the Governance Project progresses, accounting for any changes in committees, committee responsibilities and review and approval processes. With this in mind, any revisions or additions to the structure and therefore the calendar are likely to be implemented from April 2022 onwards, at which point a revised Calendar will be brought to Board. Furthermore, consideration may be required to some of the timings of meetings once more meetings return to a face-to-face format, rather than the Microsoft Teams based meetings (or hybrids thereof) as individual member's availability may need reviewing. This could include moving Board meetings to later in the day to allow for members' travel arrangements.

Once the calendar is approved, meeting invites will be updated to accommodate the new meetings.

In addition to the meeting calendar, a revised Board Plan (appendix 2) is included for review and approval. This plan incorporates key items for discussion across agreed agenda categories, highlights regulatory and contractual items and covers both the public and confidential Board sessions from November 2021 to March 2023 and is in line with the current matters reserved and committee annual work plans. A summary and combined Board calendar and Board plan version (appendix 3) is also provided.

The Board of Directors is asked to consider the meetings calendar and Board plan (taking into account the possible impact of the on-going Governance Project) and if in agreement, approve:

- The proposed Court, Board and Committee calendar for January 2022 through to March 2023
- The proposed Board Plan for January 2022 through to March 2023

Appendices

Appendix 1 – Court, Board and Committee Meeting Calendar up to March 2023

Appendix 2 – Detailed Board Plan up to March 2023

Appendix 3 – Summarised Board calendar and plan combined

Court of Governors, Board of Directors and Sub-Committee Dates January 2022 – March 2023

Month	Court of Governors	Board of Directors	Board Strategy / Development Day	Nomination and Remuneration Committee	Finance Committee	Audit & Risk Committee	Quality and Safety Committee	People Committee	Research Committee	Pension Trustees	Investment Committee
January 2022	**28 January 2022** 11.00 am – 3.00 pm **(Development Day with BoD)**	**27 January 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**20 January 2022** 9.30 am – 3.30 pm NHS Providers **28 January 2022** 11.00 am – 3.00 pm **(With CoG)**	**11 January 2022** 9.00 am – 10.00 am		**14 January 2022** 9.30 am – 12.30 pm					**January 2022** (date to be confirmed)
February 2022	**25 February 2022** 11.00 am – 2.00 pm						**8 February 2022** 9.30 am – 12.30 pm	**10 February 2022** 3.00 pm – 5.00 pm	**2 February 2022** 2.00 pm – 5.00 pm	**3 February 2022** 10.00 pm – 1.30 pm	
March 2022		**24 March 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**17 March 2022** 9.30 am – 3.30 pm NHS Providers **25 March 2022** 11.00 am – 3.00 pm **(With CoG)**	**8 March 2022** 9.00 am – 12.00 pm	**14 March 2022** 9.30 am – 12.30 pm						
April 2022			**21 April 2022** 9.30 am – 3.30 pm NHS Providers			**18 April 2022** 9.30 am – 12.30 pm	**12 April 2022** 9.30 am – 12.30 pm				
May 2022	**27 May 2022** 11.00 am – 2.00 pm	**26 May 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**25 May 2022** 9.30 am – 3.30 pm NHS Providers	**10 May 2022** 9.00 am – 10.00 am			Quality Account - Page Turning session **26 May 2022** 13.30 pm – 15.30 pm	**12 May 2022** 3.00 pm – 5.00 pm	**4 May 2022** 2.00 pm – 5.00 pm		**May 2022** (date to be confirmed)
June 2022	**9 June 2022** 11.00 am – 3.00 pm **(Development Day with BoD)**	**09 June 2022** Quality Account Approval 9.30am – 10.30am	**9 June 2022** 11.00 am – 3.00 pm **(With CoG)**				**14 June 2022** 9.30 am – 12.30 pm				
July 2022		**28 July 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**29 July 2022** 9.30 am – 3.30 pm	**5 July 2022** 9.00 am – 10.00 am	**18 July 2022** 9.30 am – 12.30 pm	**18 July 2022** 9.30 am – 12.30 pm				**7 July 2022** 10.00 pm – 1.30 pm	
August 2022						Annual Report Page Turning session - Date & time TBC	**16 August 2022** 9.30 am – 12.30 pm	**11 August 2022** 3.00 pm – 5.00 pm	**3 August 2022** 2.00 pm – 5.00 pm		**August 2022** (date to be confirmed)
September 2022		**29 September 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm		**6 September 2022** 9.00 am – 10.00 am	**23 September 2022** 9.30 am – 12.30 pm	**19 September 2022** 9.30 am – 12.30 pm				**September 2022** 10.00 pm – 1.30 pm (date to be confirmed)	
October 2022	**28 October 2022** 11.00 am – 3.00 pm **(AGM) & CoG / BoD joint session**						**11 October 2022** 9.30 am – 12.30 pm				
November 2022		**24 November 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**4 November 2022** 9.30 am – 3.30 pm	**8 November 2022** 9.00 am – 12.00 pm	**18 November 2022** 9.30 am – 12.30 pm			**10 November 2022** 3.00 pm – 5.00 pm	**2 November 2022** 2.00 pm – 5.00 pm		**November 2022** (date to be confirmed)
December 2022	**16 December 2022** 11.00 am – 2.00 pm						**13 December 2022** 9.30 am – 12.30 pm			**December 2022** 10.00 pm – 1.30 pm (date to be confirmed)	

Month	Court of Governors	Board of Directors	Board Strategy / Development Day	Nomination and Remuneration Committee	Finance Committee	Audit & Risk Committee	Quality and Safety Committee	People Committee	Research Committee	Pension Trustees	Investment Committee
January 2023		**26 January 2023** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm		**10 January 2023** 9.00 am – 10.00 am		**23 January 2023** 9.30 am – 12.30 pm					
February 2023							**14 February 2023** 9.30 am – 12.30 pm	**9 February 2023** 3.00 pm – 5.00 pm	**1 February 2023** 2.00 pm – 5.00 pm		
March 2023	**31 March 2023** 11.00 am – 3.00 pm **(Development Day with BoD)**	**30 March 2023** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**31 March 2023** 9.00 am – 11.00 pm **(BoD)** 11.00 am – 3.00 pm **(With CoG)**	**7 March 2023** 9.00 am – 12.00 pm	**13 March 2023** 9.30 am – 12.30 pm						

PUBLIC - Part 1
CONFIDENTIAL - Part 2
Regulatory/Contractual Items
Bold & Italic - awaiting confirmation / NEW

St Andrew's HEALTHCARE

St Andrew's Healthcare Board Plan 2021 - 2022

St Andrew's Healthcare Board Plan 2022-2023

	Nov Public	Nov Confidential	December (additional)	Jan Public	Jan Confidential	February	March Public	March Confidential	April	May Public	May Confidential	June (additional)	July Public	July Confidential	August	Sept Public	Sept Confidential	October	Nov Public	Nov Confidential	December	Jan Public	Jan Confidential	February	March Public	March Confidential
Chair Update	Chair Update	Chair Update		Chair Update	Chair Update		Chair Update	Chair Update		Chair Update	Chair Update		Chair Update	Chair Update		Chair Update	Chair Update		Chair Update	Chair Update		Chair Update	Chair Update		Chair Update	Chair Update
CEO Assurance	CEO Report	CEO Legal Report		CEO Report	CEO Legal Report		CEO Report	CEO Legal Report		CEO Report	CEO Legal Report		CEO Report	CEO Legal Report		CEO Report	CEO Legal Report		CEO Report	CEO Legal Report		CEO Report	CEO Legal Report		CEO Report	CEO Legal Report
Operations	Divisional Presentation and Patient / Carer Voice - LSSR (E Beber) Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security) ***Estates Update***			Divisional Presentation and Patient / Carer Voice - NeuroPsych (M Natarajan) Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security) ***Community Partnershps update***			Divisional Presentation and Patient / Carer Voice - CAMHS (TBC) Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security)			Divisional Presentation and Patient / Carer Voice - TBC Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security) *Estates Update*			Divisional Presentation and Patient / Carer Voice TBC Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security)			Divisional Presentation and Patient / Carer Voice TBC Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security) Community Partnershps update			Divisional Presentation and Patient / Carer Voice TBC Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security) Estates Update			Divisional Presentation and Patient / Carer Voice TBC Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security)			Divisional Presentation and Patient / Carer Voice TBC Board Performance Report (inc Divisional Performance / Finance / Covid / Information Security)	
Strategy	Strategy Update	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		Strategy Update	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		Strategy Update ***Board Assurance Framework***	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		**Strategy Update & REVIEW** Board Assurance Framework	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		Strategy Update Board Assurance Framework	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		Strategy Update Board Assurance Framework	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		Strategy Update Board Assurance Framework	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		Strategy Update Board Assurance Framework	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc		Strategy Update Board Assurance Framework	Business Development Update e.g: Provider Collaboratives, Risk and Gain Share etc
Finance			**2020-21 Audit Report Approval** **2020-21 Annual Report Approval**		Budget Principles Approval Pension Scheme Covenant			Budget Approval			Budget / Forecast Update			Budget / Forecast Update			*2021-22 Annual Report & Accounts Approval* *Bank Covenants approval* *Insurance Renewals approval*			Budget / Forecast Update			Budget Principles Approval Pension Scheme Covenant			Budget Approval
Regulatory							Data Security and Protection Toolkit submission Approval	NHS Improvement Submission Approval				**Approve 2021-22 Quality Account**	Responsible Officer Regulations (Appraisal & Validation) approval Caldicott Guardian & SIRO Annual Report approval Modern Slavery Act Renewal approval Mortality Surveillance Report approval			Business Continuity Planning / Disaster Recovery (EPRR) submission approval										NHS Improvement Submission Approval
Patients / Quality / Operational	IPC Annual Report approval			**Safer Staffing Report - NEW**			Safer Staffing Report			Safer Staffing Report			Complaints Annual Report approval Safer Staffing Report			Safeguarding Annual Report approval Safer Staffing Report			Safer Staffing Report IPC Annual Report approval			Safer Staffing Report			Safer Staffing Report	
People	Recruitment Health & Safety Annual Report Gender Pay Gap approval Ethnicity Pay Gap Report approval ***Education St Andrew's College / Academic Centre***			Your Voice Employee Relations / Speak Up Guardians / Whistleblowing	Succession Planning Remuneration Policy approval		Patient, Carer and Employee Promise	Executive Pay Review & approval Benchmarking Pay Review		Succession Planning			People Strategy Overview	Reward update		Education St Andrew's College / Academic Centre Diversity and Inclusion strategy and annual report approval			Recruitment update Health & Safety Annual Report Gender Pay Gap Report approval Ethnicity Pay Gap Report approval			Your Voice Employee Relations / Speak Up Guardians / Whistleblowing	Succession Planning Remuneration Policy approval		Patient, Carer and Employee Promise	Executive Pay Review & approval Benchmarking Pay Review
Governance / Assurance	**Sub-Committee Reports:** Audit & Risk Committee Finance Committee Quality & Safety Committee People Committee Board Annual Planner approval **Governance Oversight Group update**	**Sub Committee Reports:** NomRemCo FinCom ***Policy Approvals (when applicable)***		**Sub-Committee Reports:** Audit & Risk Committee Quality Safety Committee People Committee Governance Oversight Group update	**Sub Committee Reports:** NomRemCo Board Matters Reserved & Delegations of Authority Trustee/Director Responsibilities Update ***Policy Approvals (when applicable)***		**Sub-Committee Reports:** Quality Safety Committee Research Committee People Committee Pensions Committee Board & Sub-Committee Effectiveness Review Health & Safety Review Risk Information Management System Review Governance Oversight Group update	**Sub Committee Reports:** NomRemCo Investment Com ***Policy Approvals (when applicable)***		Annual Fit & Proper Statement & Related Party Transactions ***Committee Annual Assurance Reports*** ***Research Committee Annual Report*** **Sub Committee Reports:** Audit & Risk Committee Quality Safety Committee Research Committee People Committee Governance Oversight Group update	**Sub Committee Reports:** NomRemCo FinCom **Policy Approvals (when applicable)**		**Sub-Committee Reports:** Audit & Risk Committee Quality Safety Committee Pensions Committee Governance Oversight Group update	**Sub Committee Reports:** NomRemCo FinCom Investment Com Board Matters Reserved & Delegations of Authority **Policy Approvals (when applicable)**		**Sub-Committee Reports:** Audit & Risk Committee Quality Safety Committee Research Committee People Committee Pensions Committee Change of Directors / Company Officers (DECISION) Governance Oversight Group update	**Sub Committee Reports:** NomRemCo FinCom Investment Com ***Policy Approvals (when applicable)*** ***Approval of external Auditors (pre-AGM) (3xyearly)*** ***Charity's Objects or Articles of Association (if applicable - Pre AGM)***		**Sub-Committee Reports:** Quality Safety Committee Research Committee People Committee Board & Sub-Committee Effectiveness Review Annual Risk Management Report and Risk Appetite approval Governance Oversight Group update	**Sub Committee Reports:** NomRemCo FinCom ***Policy Approvals (when applicable)***		**Sub-Committee Reports:** Audit & Risk Committee Quality Safety Committee Pensions Committee Board Annual Planner Governance Oversight Group update	**Sub Committee Reports:** NomRemCo Investment Com Board Matters Reserved & Delegations of Authority Trustee/Director Responsibilities Update **Policy Approvals (when applicable)**		**Sub-Committee Reports:** Quality Safety Committee Research Committee People Committee Health & Safety Review Risk Information Management System Review Governance Oversight Group update	**Sub Committee Reports:** NomRemCo FinCom ***Policy Approvals (when applicable)***

Board of Directors
January 2022 – March 2023

Month	Board of Directors	Board Strategy / Development Day
January 2022	**27 January 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**20 January 2022** 9.30 am – 3.30 pm NHS Providers **28 January 2022** 11.00 am – 3.00 pm **(With CoG)**
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – Neuropsychiatry • Integrated Quality & Performance Report • Community Partnerships Update • Strategy Update • Safer Staffing Report • Your Voice update • Employee Relations / Freedom to Speak Up Guardians / Whistleblowing • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Budget Principles Decision • Pensions Scheme Covenant • Succession Planning • Remuneration Policy approval • Committee updates and escalation reports	20 January - NHS Providers Board Development Programme – Workshop 3
March 2022	**24 March 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**17 March 2022** 9.30 am – 3.30 pm NHS Providers **25 March 2022** 11.00 am – 3.00 pm **(With CoG)**
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – CAMHS • Integrated Quality & Performance Report • Strategy Update • Board Assurance Framework approval • Data, Security & Protection Toolkit submission approval • Safer Staffing Report • Patient, Carer and Employee Promise • Health & Safety Review • Risk Information Management System Review • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Budget Approval • NHS Improvement Submission Approval • Executive Pay Review & approval • Benchmarking Pay Review • Committee updates and escalation reports	17 March - NHS Providers Board Development Programme – Workshop 4

May 2022	**26 May 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**25 May 2022** 9.30 am – 3.30 pm NHS Providers
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – TBC • Integrated Quality & Performance Report • Estates Update • Strategy Update and Review • Board Assurance Framework • Safer Staffing Report • Succession Planning • Committee Annual Assurance Reports • Annual Fit and Proper Statement / Related Party Transaction / Declarations of Interest • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Budget / Forecast Update • Committee updates and escalation reports	NHS Providers Board Development Programme – Workshop 5
June 2022 (additional meeting)	**09 June 2022** 9.30 am – 10.30 am	**9 June 2022** 11.00 am – 3.00 pm **(With CoG)**
Key topics for discussion	• Approve 2021-2022 Quality Account	
July 2022	**28 July 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**29 July 2022** 9.30 am – 3.30 pm
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – TBC • Integrated Quality & Performance Report • Strategy Update • Board Assurance Framework • Responsible Officer Regulations (Appraisal and Validation) approval • Caldicott Guardian & SIRO reports approval • Modern Slavery Act Renewal approval • Mortality Surveillance Report approval • Complaints Annual Report approval • Safer Staffing Report • People Strategy Overview • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Budget / Forecast Update • Reward update • Board Matters Reserved and delegations of authority • Committee updates and escalation reports	

September 2022	**29 September 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – TBC • Integrated Quality & Performance Report • Community Partnerships Update • Strategy Update • Board Assurance Framework • Business Continuity / Disaster Recovery (EPRR) Submission approval • Safeguarding Annual Report approval • Safer Staffing Report • Education / St Andrew's College • Diversity & Inclusion Strategy & Annual Report • Change of Directors / Company Officers • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Annual Report & Accounts Approval • Bank Covenants approval • Insurance Renewals approval • Approval of external Auditors (pre AGM) if required • Charity's Objects or Articles of Association (if applicable - Pre AGM) • Committee updates and escalation reports	
November 2022	**24 November 2022** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**4 November 2022** 9.30 am – 3.30 pm
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – TBC • Integrated Quality & Performance Report • Estates Update • Strategy Update • Board Assurance Framework • Safer Staffing • IPC Annual Report approval • Recruitment update • Health & Safety Annual Report • Gender Pay Gap Report approval • Ethnicity Pay Gap Report approval • Employee Relations / Freedom to Speak Up Guardians • Annual Risk Management Report and Risk Appetite Approval • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Budget / Forecast Update • Committee updates and escalation reports	

January 2023	**26 January 2023** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – TBC • Integrated Quality & Performance Report • Strategy Update • Board Assurance Framework • Safer Staffing Report • Your Voice • Safeguarding Annual Report approval • Employee Relations / Freedom to Speak Up Guardians / Whistleblowing • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Budget Principles Approval • Pension Scheme Covenant • Succession Planning • Remuneration Policy approval • Board Matters Reserved & Delegations of Authority • Trustee/Director Responsibilities • Committee updates and escalation reports	
March 2023	**30 March 2023** Pt1 9.00 am – 12.00 pm Pt 2 12.15 pm – 14.00 pm	**31 March 2023** 9.00 am – 11.00 pm **(BoD)** 11.00 am – 3.00 pm **(With CoG)**
Key topics for discussion	**Part One** • Chair Update • CEO Update • Divisional presentation and Patient / Carer Voice – TBC • Integrated Quality & Performance Report • Strategy Update • Board Assurance Framework • Safer Staffing Report • Patient, Carer and Employee Promise • Health & Safety Review • Risk Information Management System Review • Committee updates and escalation reports **Part Two** • Chair Update • CEO Legal Update • Business Development Update – Provider Collaboratives • Budget Approval • NHS Improvement Submission Approval • Executive Pay Review & approval • Benchmarking Pay Review • Committee updates and escalation reports	

Update Paper for Board of Directors	
Topic	Governance and Risk Implementation Programme
Date of Meeting	Thursday, 25 November 2021
Agenda Item	**8**
Author	Sally MacIntyre
Responsible Executive	Alex Owen
Discussed at Previous Board Meeting	November 2020 Review approved; September 2021 Final Report approved
Patient and Carer Involvement	Not Applicable
Staff Involvement	The Board and senior managers were interviewed by Ernst & Young as part of the Review and the Board approved the recommendations of the Review. The Chief Finance Officer, Chairman, Non-Executive Director, Company Secretariat, Risk Manager, Corporate Lawyer, Director of Workforce, Director of Performance are involved with the implementation of the recommendations
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	Governance Oversight Group

Update Summary and Key Points to Note

At the September 2021 Board Meeting, it was approved that the Charity would adopt the Ernst & Young (EY) Governance and Risk review "proposals as its framework for updating the Charity's governance and risk arrangements."

This update assures the Board that the Governance Oversight Group conducted its first meeting on 18th November. The progress of the programme,

Progress To Date:

- The Programme is reviewing the progress of the Integrated Performance Reporting, the Board Assurance Framework and the Risk Management process. All of which have progressed since EY conducted their review
- Programme Initiation Document, Programme Plan and Terms of Reference for the Oversight Group presented to the Oversight Group
- Lead Governor and Job Description of Lead Governor appointed (awaiting approval by the Court of Governors)
- CEC reviewed and recommendations completed.

Decisions Made by the Group:

- Priorities and the Programme Plan from October 2021 to April 2022 were agreed. The first priorities are to review the Committees to the Board Terms of Reference which will include membership and agenda, and review the delegation for authority and reservation of authority.
- Terms of Reference for the Oversight Group were agreed
- Programme Initiation Document presenting the governance of the programme was agreed
- No matters of concern for escalation

Significant Risks and Issues for Escalation:

- None

Decisions/Approvals required:

- Ratification of the decisions made by the Oversight Group
- Approval of the Terms of Reference for the Oversight Group

Appendices – Governance Oversight Group Terms of Reference

Governance Oversight Group

TERMS OF REFERENCE

1. Purpose

The purpose of the Governance Oversight Group (the "Group") is to provide oversight and gain assurance on the overall Programme and implementation of recommendations as laid out in the Ernst and Young Governance and Risk Review Final Report. The Group will:

- Meet at least monthly, and outside of the scheduled Board meetings
- Agree the programme plan – timescale, priorities
- Agree key performance indicators
- Agree the communication flow from the Oversight Group to the Board and the Board to the Governors
- Report to Board on progress, escalating areas of potential concern to both the Board and Responsible Executive
- Report to Board on the level of assurance gained in the effective implementation of the recommendations
- Validate the effectiveness and adequacy of all closed recommendations
- Be time bound and in-line with the agreed project timeline

The Group's responsibilities cover all aspects of Governance within the Charity.

2. Constitution and Authority

The Governance Oversight Group shall be accountable to the Board of Directors and is authorised by the Board to seek assurance on progress, providing a written report to the Board at each scheduled Board meeting and interim updates as needed.

This Terms of Reference is effective from 18th November 2021 and will be on-going until terminated by the Board of Directors upon dissolution of the Group.

3. Membership

3.1. The Governance Oversight Group shall be chaired by the Charity Chair or, in their absence one of the Non-Executive Directors within the Group membership.

3.2. Group core membership shall be made up of the following:

- Paul Burstow, Charity Chair (Chair of group)
- Andrew Lee, Non-Executive Director (Chair of Finance Committee)
- Elena Lokteva, Non-Executive Director (Chair of Audit & Risk Committee)
- Alex Owen, Chief Finance Officer
- Martin Kersey, Executive HR Director
- Sally MacIntyre, Programme Director

Whilst there is no official quorate requirement for the meeting, at least four members of the Group should be present, including the Chair or at least one Non-Executive Director and one Executive Director. Non-members may be invited to join the Group to aid discussion of a particular topic.

3.3. All members shall be required to confirm any declarations of interest at each meeting.

4. Meetings

4.1 Meetings to be held monthly

4.2 Meetings will be held in person if possible or via Microsoft Teams

4.3 Additional meetings may be convened at the request of the Chair in addition to the scheduled meetings

4.4 The Programme Director or their nominee shall act as the Secretary of the Group and maintain administrative oversight and responsibility for the Governance and Risk Review Project plan and timeline, including any associated Dashboards or project reports

5. Duties

The duties of the Group shall be:

5.1 Agree the project timeline and key project milestones and performance indicators

5.2 Approve solutions proposed by the steering group to risks, issues, and conflicts.

5.3 Report to Board on the level of assurance gained in the effective implementation of the recommendations

5.4 Agree the communication flow from the Board to the Governors

5.5 Review the Performance Dashboard

5.6 Validate the effectiveness and adequacy of all closed recommendations and request appropriate follow-up by the appropriate function or governance group/committee

5.7 To review the Risk and Issues Log

5.8 To identify and agree new recommendations that may arise through the scrutiny of the agreed recommendations

5.9 To identify any agreed recommendations that are no longer appropriate, escalating these to the Board with a clear explanation as to the reasons why and to recommend any additional requirements to Board to support the implementation of the programme.

6. Reporting Procedures and Other Matters

6.1 The Governance and Risk Review Programme Plan, Risk and Issues Log and Performance Dashboard will be updated at each meeting by the Programme Director and circulated to all members following the conclusion of the meeting for confirmation and further update as required.

6.2 The Group meeting agenda and any required papers will be circulated via email by the Programme Director (or nominee) at least 5 working days before the meeting. Topics for the agenda will be generated by the members of the Group

6.3 Notes from the meeting, any action plans or any other relevant information will be distributed to the Group members within 5 working days after the meeting.

6.4 The Chair of Group will ensure a written report on progress against the programme plan is provided to the Board at each scheduled Board meeting and interim updates as needed.

6.5 These Terms of Reference are to be approved by the Group, and ratified by the Board

November 2021

Committee Updates

Pension Trustees
Martin Kersey

Audit & Risk Committee
Elena Lokteva

Quality & Safety Committee
inc IPC Annual Report
David Sallah

People Committee
Paul Burstow

Nominations & Remuneration Committee
inc Gender and Ethnicity pay reports
Stuart Richmond-Watson

Committee Update Report to the Board of Directors

Name of Committee:

Meeting of Directors of St Andrew's Pension Trustees Limited

Date of Meeting:

7 October 2021

Chair of Meeting:

Martin Kersey

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- Selection of Fiduciary Manager
- Approval of Statement of Investment Principles, subject to consultation with Charity
- Discretionary pension increase provided by Charity
- Trustee training
- Governance review
- GMP reconciliation/rectification
- Trustee Report and Accounts

Decisions made by the Committee:

- Agreed to appoint Blackrock as Fiduciary Manager
- Agreed to sign the Trustee Report and Accounts

Implications for the Charity Risk Register or Board Assurance Framework:

- No Change for Pension Risk on the Risk Register

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Committee Update Report to the Board of Directors

Name of Committee:

Audit and Risk Committee

Date of Meeting:

18 October 2021

Chair of Meeting:

Elena Lokteva

Significant Risks/Issues for Escalation:

Whilst there has been significant progress with the improvements required over the risk management system, the Committee remains very conscious that current risk management system can provide the Board with partial assurance only.

Key issues/matters discussed:

1. St Andrew's Property Management Ltd (SAPML) accounts 31 March 2021

The Committee discussed the SAPML accounts and confirmed that ARC is satisfied with the quality and integrity of the SAPML financial statements and recommends them for signing subject to post balance sheet event disclosures and the Letter of Comfort being in place.

2. St Andrew's Healthcare (SAH) Statutory Accounts 31 March 2021

The Committee reviewed the latest updated accounts, following a number of corrections and adjustments and discussed mitigating actions, post balance sheet events, timelines with regard to the AGM, future capital expenditure, banking conditions and covenants, as well as the opinion of the external auditors. The Committee agreed to hold an additional meeting prior to the Board meeting at which the accounts will be approved.
At this meeting the committee will:

- Reconfirm the post balance sheet events statement
- Reconfirm the going concern statement
- Review and approve the PwC letter

The Committee endorsed the Annual Report and accounts at this stage, but deferred approval until the additional meeting.

3. Price Waterhouse Coopers audit report

The Committee noted the audit report from PwC and discussed the auditor's views on the latest adjustments and amendments to the statutory accounts and agreed to defer the final review and approval of the letter until the additional ARC meeting.

4. Risk

ARC reviewed the current state of the risk management system and acknowledged a

number of hurdles in terms of moving the risk management framework to the next level of maturity, where it would be seen as “established”.

The Committee asked for more detail on the deadlines and actions being taken to close out the overdue reviews and unacceptable risks and that the functional resourcing requirement be looked at in conjunction with the EY recommendations.

The ARC received the latest review of the Material Risk Register, of the 19 material risks, 15 have been reviewed with the Executive Responsible since the last ARC update and two were identified as having changes to their residual ratings, with one increased, namely “Risk R1008 – Development of Community Services”.

The Committee was also made aware of the specific impact of staffing related challenges on the material risks, with 13 risks directly impacted by the current staffing challenges.

A revised risk management assurance methodology was reviewed, that reinforces the integration of risk management with Internal Audit and the effective use of Datix. The Committee confirmed its agreement to the new methodology.

5. Internal audit

The Committee reviewed the current internal audit actions dashboard and noted an increase in open actions as a result of four new audits being published. Of the new audits, two were rated with partial assurance and two with adequate assurance levels. It noted four actions overall were now overdue, one of medium and 3 of low priority.

The Committee reviewed and endorsed the proposed new Internal Audit assurance methodology (in-line with risk management above) and requested that the impact of this be clearly highlighted in future reports.

ARC received and considered a paper on IA benchmarking and resource requirements. The Committee discussed the need for an independent external assessment of the function, along with reviewing current line management of the IA functions.

The Committee agreed that a decision over IA should be made at the January ARC meeting.

6. Counter fraud

The Committee received and reviewed the latest counter fraud activity update that included information on proactive counter-fraud work, referrals for potential fraudulent activity in the previous period and wider horizon scanning for issues that may impact the Charity. The Committee was satisfied with Local Counter Fraud Specialist work.

7. Emergency Preparedness, Resilience and Response (EPRR) Annual Standards Submission 2021-2022

The Committee received and noted the Charity’s EPRR Annual Submission for 2021-2022. The change to the reporting timeline will be reflected in the ARC’s annual work plan.

8. Annual Gifts and Hospitality Register review

ARC noted and approved the review, recognising the low level of registrations in this area and was satisfied with the system in place and welcomed the changes in administration and reporting.

9. Audit and Risk Committee Effectiveness Review

The Committee received and considered the findings of the recently completed review. The committee noted that there were 4 main areas for improvement identified within the report:

- Engagement with key Executive stakeholders
- Composition of the Committee
- Length of agenda and pack
- Communications between meetings

The Committee agreed that the frequency of meetings should remain quarterly and that it was important to improve the quality of committee papers, including improving the quality of the cover sheets and an increased use of data and graphs. Also, that more workshops on specific topics would be a good idea and would aid engagement.

Decisions made by the Committee:

- Approved the SAPML accounts subject to post balance sheet event disclosures and the Letter of Comfort being in place.
- Agreed to the continued deferral of approving the SAH accounts until they are presented at the pre-Board ARC meeting.
- Approved the annual Gifts and Hospitality Register Review
- Agreed that ARC meetings will remain quarterly within the Board and Committee Calendar.
- Approved a revised assurance methodology within the Risk Management and Internal Audit functions.

Implications for the Charity Risk Register or Board Assurance Framework:

A revised risk management assurance methodology was approved. The new methodology adopted in both the Risk and IA functions reinforces the integration of the two functions and systems, as well as aids the effective use of Datix.

The impact of these changes to assurance ratings are to be monitored and highlighted in future ARC reports and updates.

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- None

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meeting: 12 October 2021

Chair of Meeting: Professor David Sallah

Significant Risks/Issues for Escalation:

- Solutions to the patient record system issues highlighted within the Community Services division are being embedded and the committee continues to monitor the impact and outcome

- Staffing number levels and solutions remain a key focus, with the eRostering solution and implementation of MHOST ongoing.

Key issues/matters discussed:

- **Essex Division deep dive**

  The deep dive was presented by the division and noted. Key areas of focus discussed included, staffing, leadership and occupancy along with the recognised improvements in quality, clinical skills and training.

- **Community Partnerships deep dive follow-up**

  The deep dive follow-up was presented by the division and noted. Discussions focussed on the previous challenges relating to the patient record system and the improvements seen since the last update. The committee agreed that a further update in this area would be required at the next meeting.

- **Infection Prevention and Control Annual Report**

  The committee noted the report. The report highlighted work and achievements within IPC over the last year, most notably in relation to Covid, and the planned work and activities for the year ahead.

- **Executive Medical Director report**

  The committee noted the EMD report, that included updates on CQC visits, controlled drug deep dive results, review of Physical Healthcare resources and details of recently completed Quality Impact Assessments.

- **Chief Nurse report**

  The committee noted the Chief Nurse report, that included a new Safer Staffing Tool, further information on the new Nursing Strategy, an update on the implementation of the new eRostering solution and confirmation of changes to the Handover policy and processes.

- **Quality Improvement Plan**
  The quality Improvement plan was presented and noted, highlighting the aggregation of the original action plan with the latest CQC responses.

- **Serious Incidents**

  The serious incidents in the last period were reviewed. It was noted that the reduction in reported Sis continues and it was agreed that internally investigated incidents as well as reportable Sis would be reported in future.

- **Integrated Performance Report**

  The Integrated Performance Report template was presented and noted.

- **Covid-19 update**

  The committee noted the latest Covid update that highlighted the latest Covid statistics, that the booster vaccination programme was now underway, and that the flu vaccine was being administered at the same time.

- **East Midlands Mental Health Patient Safety Programme**

  The committee received a report that gave a broad outline of the work of the East Midlands Patient Safety Network, for which the EMD is the current Chair. The network provides an opportunity to share best practice within three key areas: Improving sexual safety on wards; suicide prevention and reduction; reducing restrictive practices.

- **Quality and Safety Group (QSG)**

  The Quality and Safety Group report was received and noted.

- **Mental Health Law Steering Group (MHLSG)**

  The Mental Health Law Steering Group report was received and noted.

Decisions made by the Committee:

- **Infection Prevention and Control Annual Report**
  The committee approved the report for submission to the Board

- **Quality and Safety Group (QSG)**
  The committee approved the merging of the Clinical Governance Oversight Group with the QSG

Implications for the Charity Risk Register or Board Assurance Framework:

- Material Risk 868 – Covid-19 Infection and Pandemic - following a comprehensive deep dive and a move to the new Datix scoring system, the likelihood and impact have remained consistent. Under the new 5x5 scoring matrix used for Material Risk, the residual score is now 9.

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- Infection Prevention and Control Annual Report

Appendices:

- Appendix 1 – Infection Prevention and Control Annual Report

Paper for Board of Directors	
Topic	Infection Prevention and Control Annual Report 2020/2021
Date of Meeting	Thursday, 25 November 2021
Agenda Item	**9**
Author	Pixy Strazds
Responsible Executive	Andy Brogan
Discussed at Previous Board Meeting	Not previously discussed by Board.
Patient and Carer Involvement	No involvement at this time due to report predominately data collection. IPC team work plan identifies the need for developing processes for patient/carer involvement.
Staff Involvement	Heads of Nursing and Ward Managers involved with producing the data and IPC team attend Ward Manager meetings.
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒
Key Lines Of Enquiry:	**S** ☒ **E** ☐ **C** ☐ **R** ☐ **W** ☐
Strategic Focus Area	Quality ☒ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Considered at Committee Meetings	IPCG, CEC and QSC.

Report Summary and Key Points to Note

This is the Infection Prevention and Control Annual report for 2020/2021, which identifies work and achievements over the last year and looks forward to the work for 2021/2022. The report has been reviewed and approved by the Quality & Safety Committee.

The Charity had commissioned an external review of the structure and function of IPC prior to December 2019; however, the execution of the review incurred a series of delays, further impacted by the Coronavirus pandemic. The final paper was received and noted by the Charity Executive Committee in August 2020.

Pixy Strazds joined the Charity as Deputy DIPC/Head of IPC in November 2020 followed by three IPC Practitioners.

Andy Brogan Chief Nurse added the DIPC role in January 2021, thus providing the Charity with clear oversight and assurance on infection prevention in compliance with the Health and Social Care Act (2008).

The priorities and future developments are:

- Introduce rapid clinical practice audit tools.
- Dental and podiatry audit tools.
- Hand hygiene awareness campaign for May 2021, in line with the World Health Organisation hand hygiene day.
- Review IPC risk register.
- Review and develop Infection Prevention and Control Group (IPCG), with reporting templates for divisional updates.
- Identify and develop IPC link nurses.
- Work towards an award winning service.
- IPC team to commence IPC MSc.
- Review the outbreak policy.
- Learn lessons.
- Ensure generic framework for the future.

Appendices

INFECTION PREVENTION & CONTROL
ANNUAL REPORT – 2020-2021

Contents

Executive Summary

This has been an unprecedented year in healthcare with the coronavirus pandemic having a huge impact across the Charity.

Andy Brogan DIPC/Chief Nurse

It was recognised that we would need to invest in Infection Prevention and Control (IPC) resulting in a major overhaul of the service. The service was considerably enhanced with the recruitment of a Head of IPC, a team of Practitioners and administration support.

Initially we ensured we responded to the fast changing national situation providing guidance and support to clinical areas. The development of an enhanced service enabled the Charity to assess and assure our regulatory compliance and development of the Gap Analysis, which was completed in March 2021. The Gap Analysis will give the Charity Executive Committee (CEC) a full oversight of the IPC service and regulatory position.

Throughout the year NHSE/I have supported the Charity, monitoring our response to the pandemic and providing Continuous Quality Improvement training to a large cohort of staff to build our IPC knowledge and practice.

This year the Infection Prevention and Control Annual Report continues to follow the format of the Health & Social Care Act 2008 (updated 2015) to demonstrate our progress with the requirements associated with the criteria of the Act.

The report demonstrates that St Andrew's Healthcare, assisted by the new IPC service, continued to make substantial progress throughout the year in providing assurances to the Board.

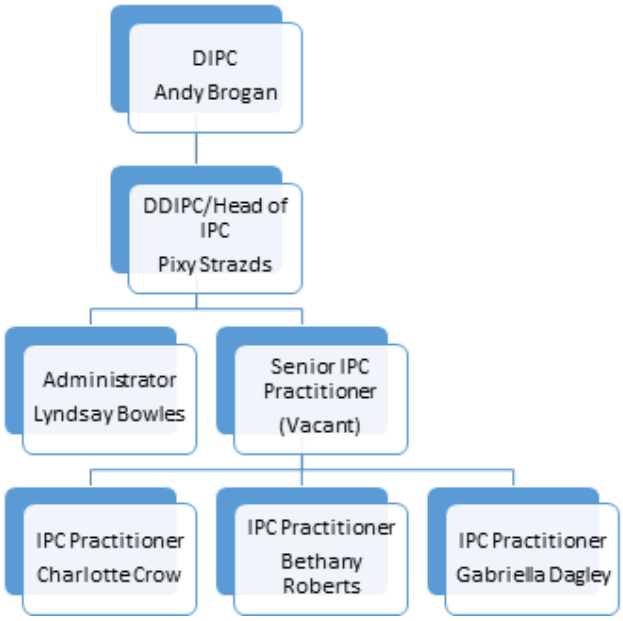
The priorities and future developments are –

- Introduce rapid clinical practice audit tools
- Dental and podiatry audit tools
- Hand hygiene awareness campaign for May 2021 in line with the World Health Organisation hand hygiene day
- Review IPC risk register
- Review and develop Infection Prevention and Control Group (IPCG) with reporting templates for divisional updates
- Identify and develop IPC link nurses
- Work towards an award winning service.

This year has been unprecedented in healthcare, and we can all be justifiably proud of our response. The support from NHSE/I, has been instrumental in assisting with the positive changes seen. None of this could have been achieved without the positive engagement from staff which we are truly thankful and appreciate their continued vigilance.

Introduction

St Andrew's Healthcare recognises the obligation placed upon it by the Health & Social Care Act 2008 (updated 2015). During 2020/2021 the Charity committed to majorly invest in the Infection Prevention and Control (IPC) service leading to the new structure below.



The new IPC team began to join the Charity in November 2020. All posts except the Senior IPC Practitioner are now in situ.

This annual report will reflect the changes following the creation of the new IPC service and seeks to assure the Charity Executive Committee (CEC) and Board of Trustees of the progress made to ensure compliance with the Health & Social Care Act 2008 (updated 2015). This report will also identify key priorities for 2021/2022 to continue improvements identified in the Annual Work Plan following a completed Gap Analysis in March 2021.

This Annual Report fulfils the legal requirements of section 1.1 and 1.3 of the Health & Social Care Act 2008 (updated 2015) and complies with the Care Quality Commission (CQC) Code of Practice.

10 Criterion of the Health and Social Care Act 2008

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them

Prior to April 2020, the Infection Prevention and Control (IPC) service was composed of one designated IPC Lead (Nurse) across Northampton, Essex, Birmingham and Nottingham hospital sites, and supported by IPC champions from each site.

The Charity had commissioned an external review of the structure and function of IPC prior to December 2019; however, the execution of the review incurred a series of delays, further impacted by the coronavirus pandemic. The final paper was received and noted by the Charity Executive Committee in August 2020.

In April 2020, James Severs, Director of Physical Healthcare joined the Charity and supported the pandemic response, taking responsibility for IPC as Director of Infection Prevention and Control (DIPC) from the departing Chief Nurse.

The need to invest in IPC practice was recognised, and in May 2020, financial investment was secured to introduce a new senior post, Head of Infection Prevention and Control/Deputy Director of Infection Prevention and Control. The coronavirus pandemic significantly increased demand for IPC qualified and experienced practitioners, which delayed recruitment, however in August 2020, Pixy Strazds was appointed as our new Head of IPC/DDIPC, starting work with the Charity in late November 2020.

In August 2020, additional investment to increase capacity of the IPC function across the Charity by three IPC practitioners and designated administration support was underway. By January 2021, our new IPC practitioner team included Bethany Roberts, Charlotte Crow and Gabriella Dagley, with designated IPC administration support from Lyndsay Bowles who joined us in March 2021.

In December 2020, after over 19 years' service, the Charity said "bon voyage" to Sue Knipes, IPC Lead, who left the Charity for a new role in a neighbouring NHS trust. James Severs, Director of Physical Healthcare and DIPC during Sue's tenure said, "*Sue's passion and dedication to improving infection prevention and control practices within the Charity was evident from our first day working together. She has provided a firm foundation for us to build upon, and many of her colleagues will remember her contribution to the IPC agenda. We would like to acknowledge this within our annual IPC report, and wish her all the very best in her new role*".

During the recruitment to the new IPC service, the Charity was grateful for the support offered by deputy DIPC(s) from NHS England-Improvement, the Chief Nursing and Quality Officer from Northamptonshire Clinical Commissioning Group, representatives from the National IPC team.

In November 2020, Andy Brogan, Chief Nurse joined the Charity and after a review of the executive portfolio, assumed the role of DIPC in January 2021, supported by Pixy Strazds, Head of IPC and Deputy IPC.

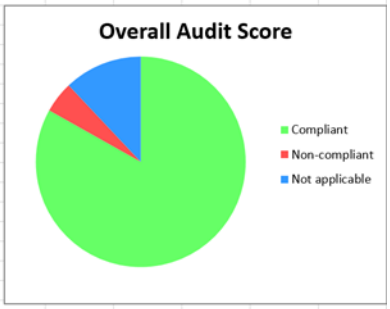
A Gap Analysis was completed in March 2021, which will provide direction of the IPC Work Plan for 2021/2022.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Infection Prevention & Control Audit Tool

In Patient Area:	
Auditors:	
Link Practitioner:	
Date of Audit:	
Ward Manager:	

		Compliant	Non-compliant	Not applicable	% Score
Section 1	IPC Systems & Processes	20	2	2	90.91
Section 2	Clean Environment - all areas	13	1	1	92.86
Section 3	Toilets / bathrooms and shower rooms	10	0	3	100.00
Section 4	Waste	5	0	0	100.00
Section 5	Patient Medical Equipment	5	1	0	83.33
Section 6	Hand Hygiene	8	2	1	80.00
Section 7	Sluice	13	0	1	100.00
Section 8	Store Room	2	2	0	50.00
Section 9	Treatment Room	14	0	8	100.00
Section 10	Kitchen / Kitchenette	18	0	1	100.00
Section 11	Sharps	10	0	0	100.00
Section 12	Personal Protective Equipment	4	0	0	100.00
Section 13	Water Coolers / Ice Machines	0	0	3	
Section 14	Linen and Laundry	9	0	0	100.00
Section 15	Domestic's Cupboard / Cleaning store room	7	0	0	100.00
	Total	138	8	20	94.52



The IPC team have implemented an online audit tool that provides a standardised method for monitoring the environment and clinical practice. Feedback of audit results enables staff to systematically identify where improvement is required to minimise infection risks and enhance the safety and quality of patient care. Management of any resulting actions is monitored by the IPC team and reviewed with Ward Managers through an audit action plan.

In addition to the IPC annual ward audits, a weekly ward manager's cleaning audit has been implemented as part of the key performance indicators (KPI) to maintain high cleanliness standards.

The IPC team have also been undertaking quality improvement projects across the Charity. One of the identified areas for improvement was the deep clean process. Work was undertaken to identify a clear pathway for staff to follow and the implementation of a sign off sheet on completion of a deep clean to ensure high standards are adhered to.

Water Safety Group

IPC attend the monthly Water Safety Group meetings as part of the multidisciplinary group formed to undertake the commissioning and development of the water safety plan. It also advises on the remedial action required when water systems or outlets are found to be contaminated and the risk to susceptible patients is increased.

Facilities/Housekeeping Cleaning Audit Results

In June 2020, Facilities/Housekeeping started using a new electronic data capture system for mobile auditing. The new *Auditor* system generates real-time digital dashboard reports, is convenient for staff to use and tracks non-compliance enabling support measures to be put in place more quickly.

The score is broken down into cleaning (C), nursing (N) and estates (E).

Audit Activity Report - Start Date: 01/06/2020 | End Date: 31/03/2021

NHS
ST. ANDREWS HEALTHCARE

			Overall Score %	93.77	Total Audits:	566	
Date	**Sync Time**	**Audits**	**Score %**	**C %**	**N %**	**E %**	**Ref**
ST ANDREWS NORTHAMPTON							
31/03/2021	13:05	FITZROY HOUSE - FERN WARD (HR)	95.03	96.34	81.82	85.00	593
31/03/2021	12:57	KEMSLEY SOUTH - WALTON (HR)	96.05	96.86	84.48	83.78	592
31/03/2021	10:55	32A BERKELEY CLOSE - 1F (HR)	97.84	99.05	91.38	85.29	591
31/03/2021	09:33	FITZROY HOUSE - WILLOW WARD (HR)	97.96	99.64	92.86	78.13	590
30/03/2021	12:52	WILLIAM WAKE HOUSE - SUNLEY - 1F (HR)	98.08	98.25	97.14	93.75	589
30/03/2021	09:52	WILLIAM WAKE HOUSE - HAWKINS (HR)	92.41	95.01	85.45	61.36	588
30/03/2021	10:36	BILLING LODGE - GF (HR)	53.33	57.41	57.14	60.00	587
30/03/2021	10:04	BILLING LODGE -1F (HR)	71.43	72.31	50.00	66.67	586
29/03/2021	14:40	WANTAGE GATE - 184 BILLING ROAD - GF (HR)	98.31	98.15	100.00	100.00	585
29/03/2021	14:34	WANTAGE GATE - 184 BILLING ROAD - 1F (HR)	96.67	96.30	100.00	100.00	584

Introduction of new products

Tristel is the new chlorine dioxide cleaning product to be introduced for use. It has broad spectrum efficacy within short contact times - 30 seconds to five minutes and has sporicidal, mycobactericidal, virucidal, fungicidal and bactericidal efficacy.

There was an initiative in February 2021 for the *GOJO* product range of antiseptic skin treatments, including soap, alcohol gel and hand medic conditioner to be introduced across the Charity.

The dispensers are located at handwashing stations and in receptions where hand gel is frequently used. This being introduced to help maintain the skin's moisture level/integrity after frequent hand washing/gel use to improve skin condition in an effort to alleviate possible infection reservoirs on dry and cracked hands. The skin conditioner is dermatologist tested with low PH and is compatible for use with latex gloves. Installation is due to commence in June 2021.

IPC Induction Training

The IPC team facilitate infection prevention and control training on inductions for new staff starting at the Charity. In the last 12 months there have been 43 new starters for Estates & Facilities, with 24 of them being from Housekeeping across all the sites.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

An electronic Prescribing and Administration system is in use across all wards. Clinical Pharmacists screen prescriptions to ensure appropriate and safe practice in line with National and local guidance.

Antimicrobial Formulary is in place in line with Local Primary and Secondary Care Formularies.

IM Antimicrobials for urgent use are available at all sites.

Antimicrobial use across the Charity is monitored by the Head of Pharmacy and monthly reports are a regular agenda item of the Medicines Management Operational Group (MMOG) to ensure oversight of use and trends. Information is also provided into Divisional Governance meetings.

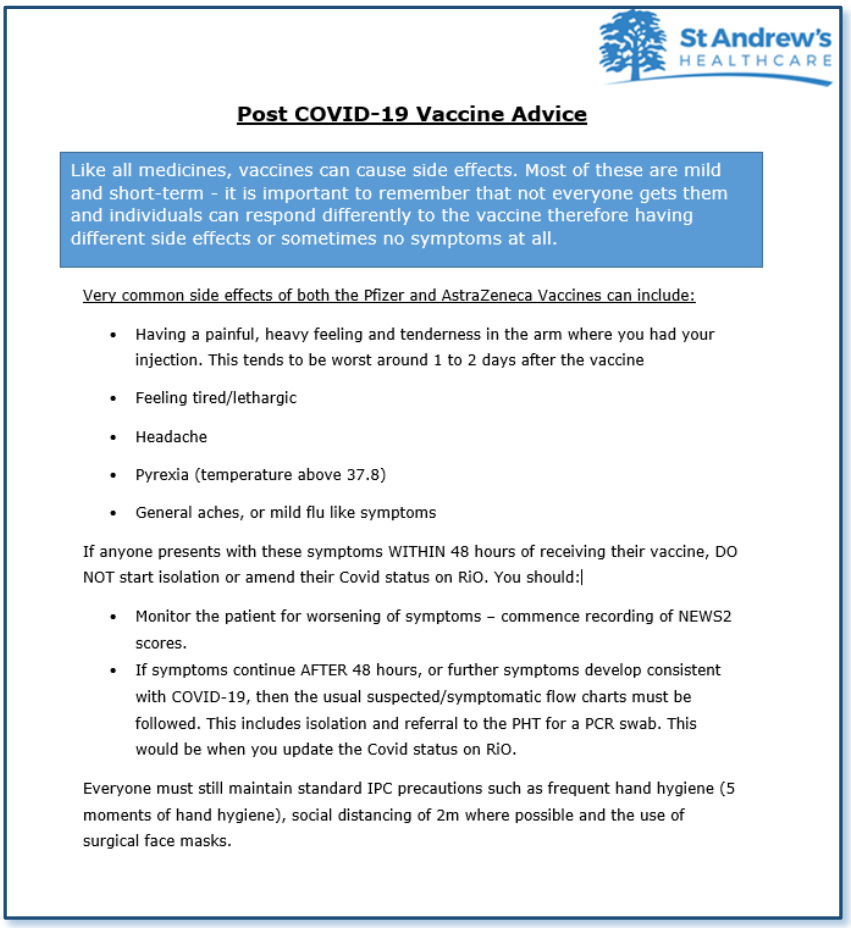
Sepsis treatment is initiated by secondary care as per relevant policies and procedures within the individual organisations.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

This year has seen the Charity move from an old version of SharePoint to a new SharePoint Online which all staff can access via their desktop through the intranet. This is mainly used by staff but the benefits to service users include that there is up-to-date information constantly refreshed by individual directorates. The content is easier to access through improved search features, allowing prompt access to key information such as vital Infection Prevention and Control policies and guidelines. This in turn supports service users and visitors obtaining further information as quickly as possible from a single source of forum. The IPC Team have worked closely to ensure the information available to staff is relevant, functional and supportive in managing any potential IPC concerns that can be easily communicated to any persons.

Through an increased presence of the IPC Team on wards, therapy areas and non-clinical settings we have provided the opportunity for service users to obtain information by asking on an informal basis face to face. There have been many opportunities for external visitors such as interpreters and external contractors to ask questions of the IPC team whilst on the wards, allowing timely responses to queries and questions they have.

We developed a Post COVID-19 Vaccine Advice poster, its simple and easy to follow format allows the guidance to be communicated amongst nursing/medical staff and also displayed on any information boards that are patient facing.



St Andrew's HEALTHCARE

Post COVID-19 Vaccine Advice

Like all medicines, vaccines can cause side effects. Most of these are mild and short-term - it is important to remember that not everyone gets them and individuals can respond differently to the vaccine therefore having different side effects or sometimes no symptoms at all.

Very common side effects of both the Pfizer and AstraZeneca Vaccines can include:

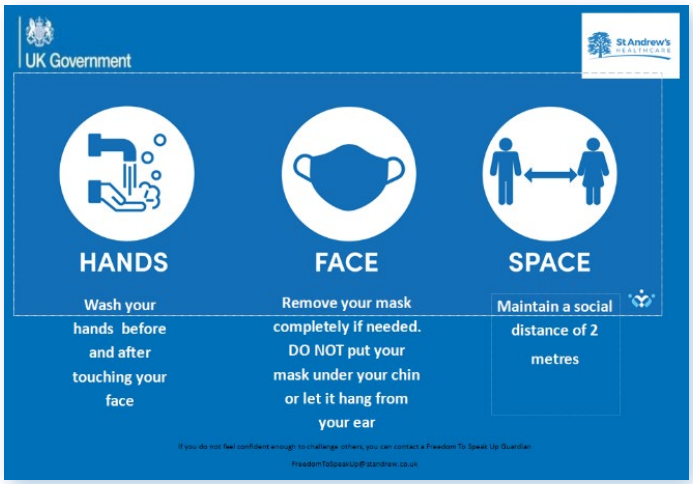
- Having a painful, heavy feeling and tenderness in the arm where you had your injection. This tends to be worst around 1 to 2 days after the vaccine
- Feeling tired/lethargic
- Headache
- Pyrexia (temperature above 37.8)
- General aches, or mild flu like symptoms

If anyone presents with these symptoms WITHIN 48 hours of receiving their vaccine, DO NOT start isolation or amend their Covid status on RiO. You should:

- Monitor the patient for worsening of symptoms – commence recording of NEWS2 scores.
- If symptoms continue AFTER 48 hours, or further symptoms develop consistent with COVID-19, then the usual suspected/symptomatic flow charts must be followed. This includes isolation and referral to the PHT for a PCR swab. This would be when you update the Covid status on RiO.

Everyone must still maintain standard IPC precautions such as frequent hand hygiene (5 moments of hand hygiene), social distancing of 2m where possible and the use of surgical face masks.

Ensuring the Charity's awareness of national IPC infection guidance was vital in reducing infection rates. Simple but effective posters were placed at the entrances to the Northampton site, reminding everyone outside at designated smoking areas to maintain social distancing, wear a mask and adhere to good hand hygiene practice. These posters showed an improvement in compliance of these measures around the Charity.

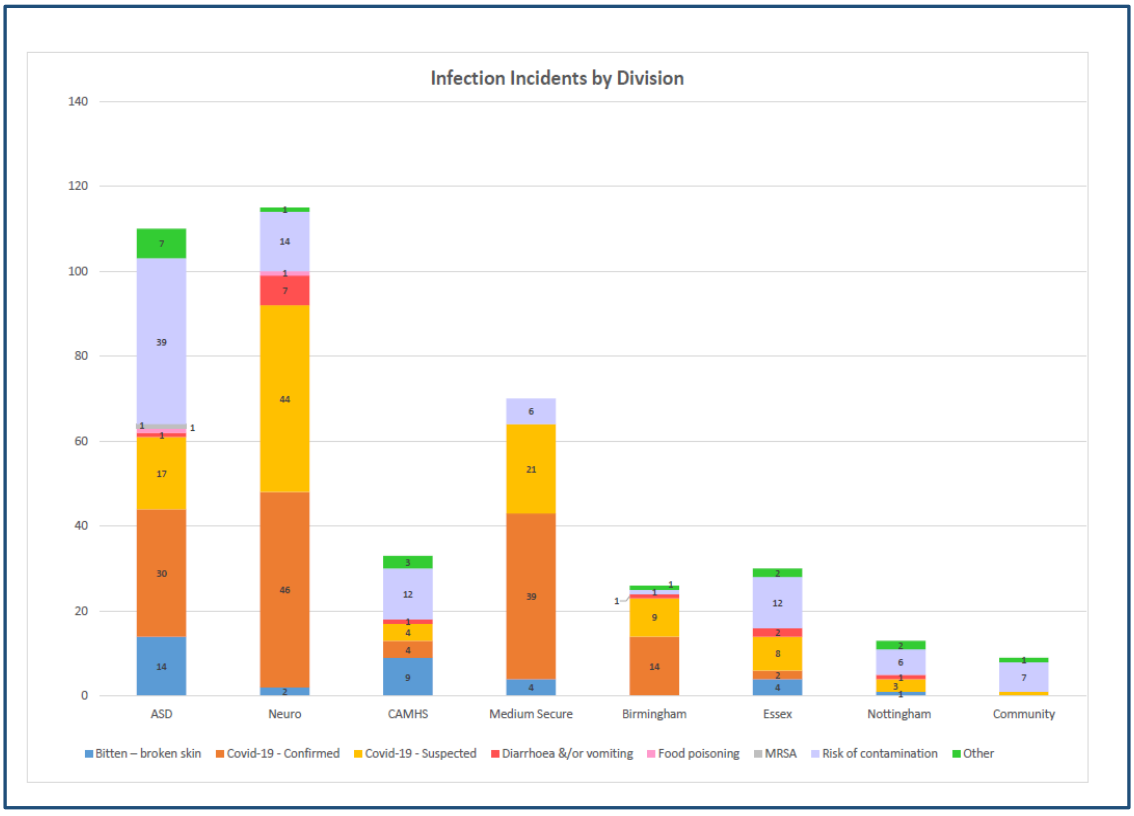


5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Overall IPC Datix for St Andrew's

Infections (April 20 – March 21)	Total No.
Bitten – broken skin	42
Covid-19 confirmed	158
Covid-19 suspected	123
Diarrhoea and/or vomiting	13
Food poisoning	2
MRSA	2
Risk of contamination	138

Infection Incidents by division



Number of Covid-19 outbreaks Apr 2020-Mar 2021: 35

Prior to March 2021 all staff testing was conducted using national testing centres. This caused a delay in testing being conducted and a delay in results being reported to the Charity via the Central Absence Team (CAT).

In March 2021 we piloted on site staff testing provided by the IPC and CA teams with microbiological support from Northampton General Hospital (NGH). This greatly improved the ability to test staff and receive results in a timely manner.

CAT team surveillance swabbing

Outbreak closure meetings

Outbreak closure meetings are undertaken on the 28th day of the monitoring phase – the purpose of this is to conclude the outbreak and discuss any recommendations or lessons learned that could be applied to prevent future outbreaks.

Post vaccination advice

The IPC team devised an easy to follow advice sheet (see page 8) containing information to guide ward staff on patients who become symptomatic post COVID-19 vaccine therefore ensuring the ward wasn't put into isolation unnecessarily but also to highlight patients who developed worsening symptoms so that this could be escalated appropriately.

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Prior to the new IPC team joining, IPC training remained in the form of e-learning and videos sent out via Charity-wide comms. In November the IPC Team began a rapid delivery of tailored IPC training in recognition of the need to support good practice during the pandemic. Clinical staff on ward-based settings were supported in their training by Specialist Nurses with practical donning and doffing competencies. In total since November over 500 staff have received face to face training:

	Clinical Ward Staff	Estates and Facilities	AHP's	Enabling Functions
Northampton	205	152	29	38
Birmingham	14	18	1	15
Essex	21	9	0	19

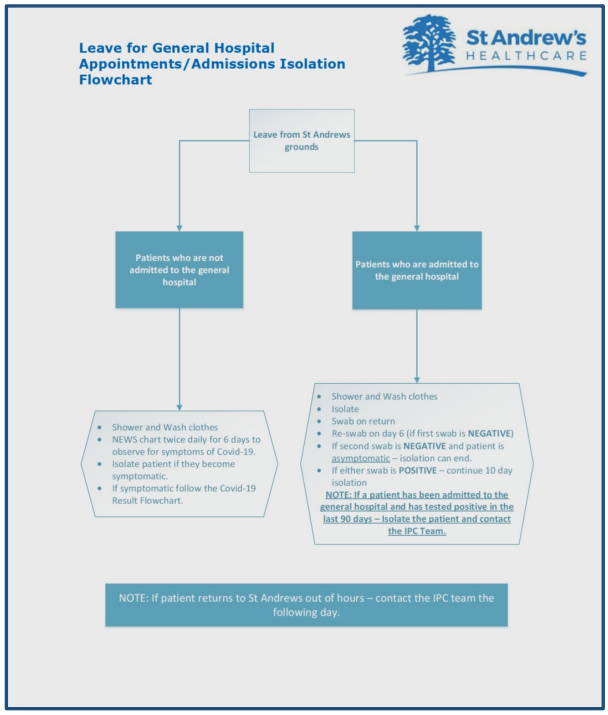
This existing 'supertraining' has been reviewed and amended with support from the Specialist Nurses and renamed IPC Refresher Training, adapting to suit the current issues around IPC in order to best advise all staff on their role managing infections with accurate guidance. Infection Prevention and Control is now a permanent feature on Charity Induction with a more comprehensive introduction to ensure new staff feel supported and are aware of their responsibilities. This year we have introduced a Nurse Manager's checklist, a tool that will help Nurse Managers to identify any hazards on a weekly basis and reinforcing their responsibilities to maintain a clean and safe environment.

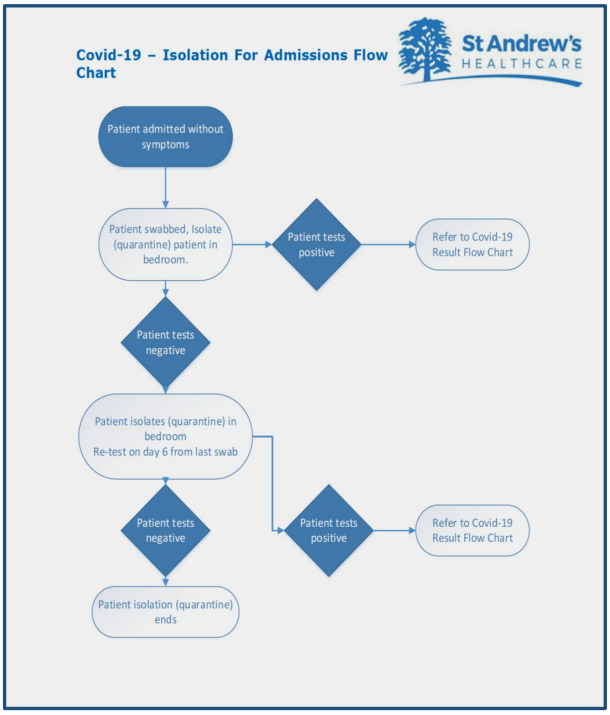
The Charity now has a formal process to follow once an outbreak is identified and declared. The outbreak policy clearly identifies the roles and responsibilities of those in senior positions whilst guiding staff working within outbreak areas on who to contact for support/the process they must adhere to.

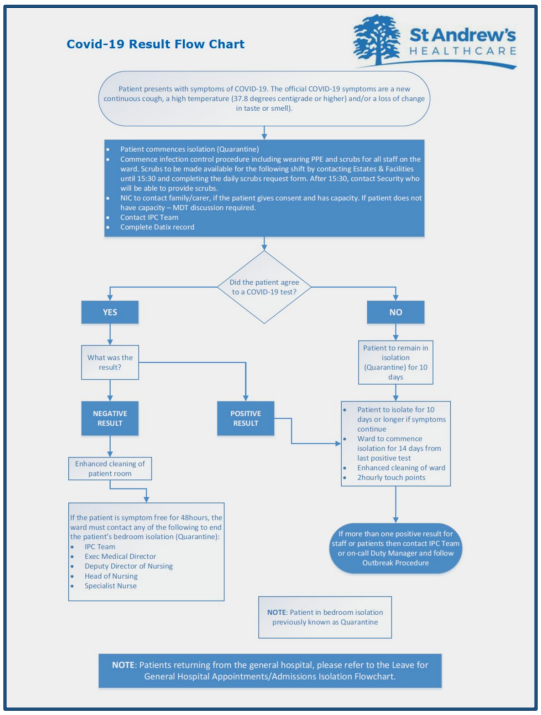
7. Provide or secure adequate isolation facilities

The Charity predominantly provides en-suite facilities to service users, however where this is not possible the MDT and LSSR Triumvirate recognised the need for alternate isolation facilities. Through a thorough appraisal, empty wards were identified and the environment made safe with IPC isolation measures to ensure correct management of symptomatic/infected service users to safely isolate. This is constantly under review and identified isolation wards are used as appropriate whilst ward moves take place.

The IPC team along with the Clinical and Professional Advisory Committee (CPAC) created and revised Isolation Algorithms to reflect any changes in national guidance. The algorithms are simple and easy to follow providing much needed clarity to ward staff on isolation facilities and the processes to identify and control infections.







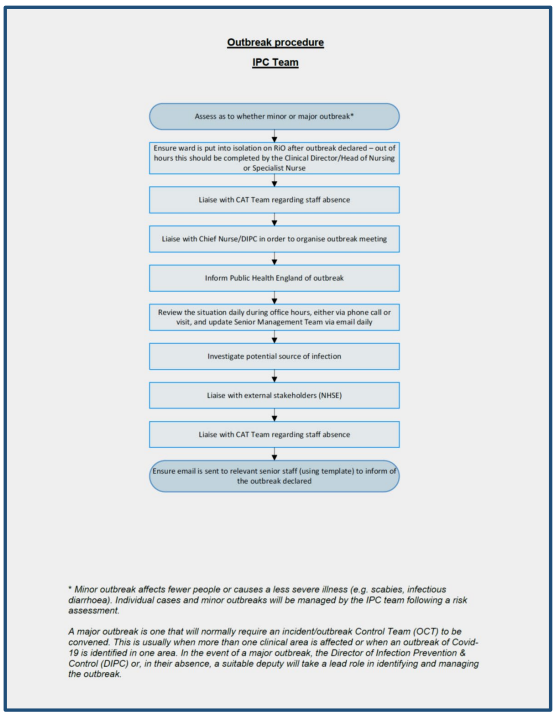
Any isolation facilities are supported and monitored by the IPC team through an increased presence on the wards. We have been able to provide verbal guidance, on shift training and the ability to challenge any poor practice or compliance to ensure effective isolation procedures are being followed.

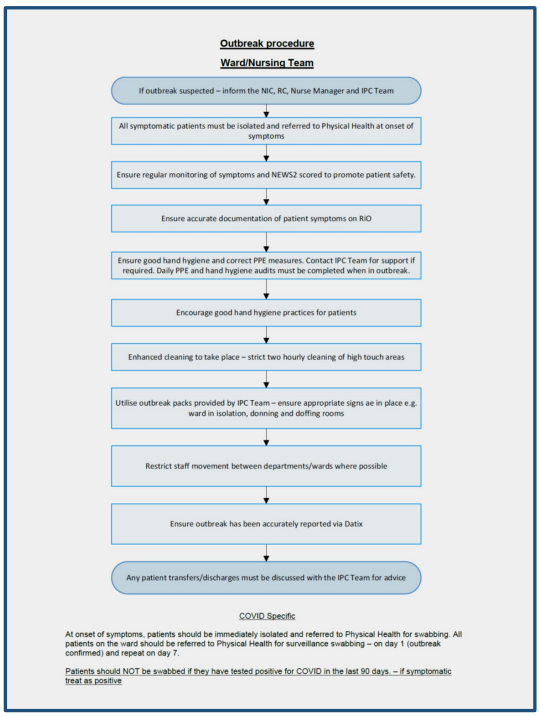
8. Secure adequate access to laboratory support as appropriate

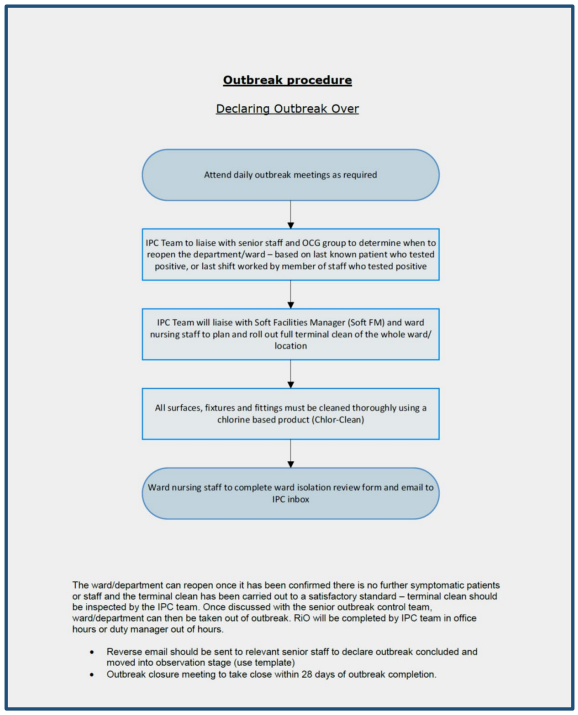
Laboratory support is provided by the local acute NHS hospitals, Northampton General Hospital (NGH), Birmingham – Queen Elizabeth (QE), Nottinghamshire – Kings Mill Hospital (KMH) and Essex – Basildon Hospital (BH). The Infection Control Lead liaises with them to discuss microbiological sample results and antibiotic sensitivities.

9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

The Outbreak policy was developed in February 2021 to ensure structure when declaring an outbreak and to ensure each part of the MDT knew what part they played within an outbreak. This was also made into easy to follow flow charts to provide assurance that the ward staff knew what to do, the Charity were aware of the IPC teams role and responsibilities in outbreak and the process of declaring outbreaks over, such as closure meetings.







Outbreak procedure

Declaring Outbreak Over

Attend daily outbreak meetings as required

IPC Team to liaise with senior staff and OCG group to determine when to reopen the department/ward – based on last known patient who tested positive, or last shift worked by member of staff who tested positive

IPC Team will liaise with Soft Facilities Manager (Soft FM) and ward nursing staff to plan and roll out full terminal clean of the whole ward/ location

All surfaces, fixtures and fittings must be cleaned thoroughly using a chlorine based product (Chlor-Clean)

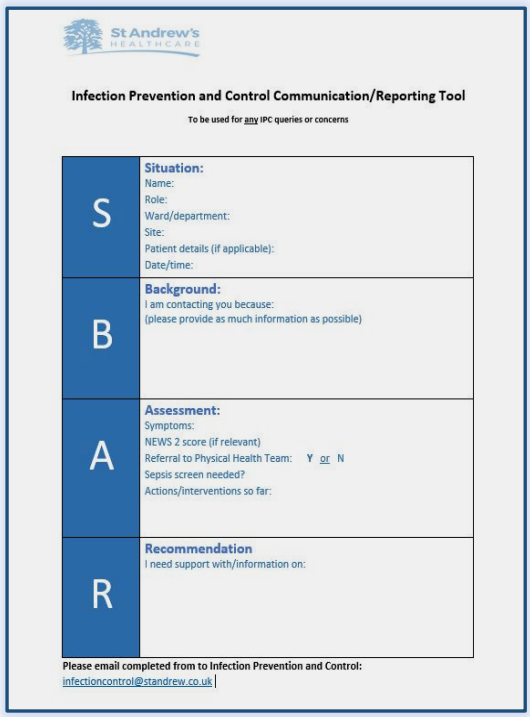
Ward nursing staff to complete ward isolation review form and email to IPC inbox

The ward/department can reopen once it has been confirmed there is no further symptomatic patients or staff and the terminal clean has been carried out to a satisfactory standard – terminal clean should be inspected by the IPC team. Once discussed with the senior outbreak control team, ward/department can then be taken out of outbreak. RiO will be completed by IPC team in office hours or duty manager out of hours.

- Reverse email should be sent to relevant senior staff to declare outbreak concluded and moved into observation stage (use template)
- Outbreak closure meeting to take close within 28 days of outbreak completion.

St Andrew's has adopted the Scottish Manual chapters 1&2 – currently awaiting the updated Public Health England guidance. This is disseminated to staff via SharePoint and has also been uploaded to every member of staffs desktop to ensure easy access.

The IPC team developed the SBAR communication tool to ensure effective communication between the wards and IPC team, the rationale for this was to make sure nursing staff could effectively communicate concerns or queries to the IPC team, and this provided assurance that the IPC had all the relevant information to provide accurate assistance and support.



St Andrew's HEALTHCARE

Infection Prevention and Control Communication/Reporting Tool

To be used for any IPC queries or concerns

S	**Situation:** Name: Role: Ward/department: Site: Patient details (if applicable): Date/time:
B	**Background:** I am contacting you because: (please provide as much information as possible)
A	**Assessment:** Symptoms: NEWS 2 score (if relevant) Referral to Physical Health Team: Y or N Sepsis screen needed? Actions/interventions so far:
R	**Recommendation** I need support with/information on:

Please email completed from to Infection Prevention and Control:
infectioncontrol@standrew.co.uk

10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Occupational Health Flu campaign 2020

Occupational health have been running a Flu vaccination programme and promoting how important it is this year, perhaps more than ever, that staff have a flu vaccination. By getting a flu vaccine staff help protect patients, colleagues, families and friends alike.

Flu Vaccination figures as of 26/01/2021 Total 1407 (31.77% of total workforce)

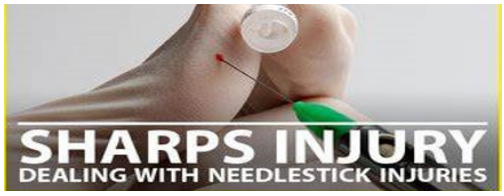
Staffing figures

Region	Employees	Work choice	Total	Flu jab Uptake of Total workforce
Northampton	2831	936	3767	31.56%
Birmingham	279	96	375	26.87%
Essex	191	86	277	36.46%
Total	3301	1118	4419	31.77%

Staff Covid 19 Vaccine Figures for the first phase up to the 31/03/21

Site	Staff uptake
Northampton	78%
Essex	84%
Birmingham	42%
Winslow	76%
Broom	100%

Just to note regarding the Birmingham numbers – the uptake of the vaccine in Healthcare workers in the West Midlands is 62% and for Birmingham and Solihull MH Trust, the uptake is 52%. While our Birmingham figures are lower than this, it reflects the lower rates generally in the West Midlands.



Occupational health have not had any reported sharps needlestick injuries during the last 12 months. This is supported by the fact that there have been no Datix reports submitted relating to sharps injury.

The IPC team have been fit testing FFP3 masks for staff that require additional level 3 personal protective equipment.

To date 190 staff across the Charity have been successfully fit tested for a FFP3 mask.

Priorities and Future Developments for 2021/2022

The Gap Analysis completed in March 2021 gives the IPC action plan and project work for 2021/2022, which includes the following –

- Rapid clinical practice audit tools
- Dental and podiatry audit tools
- Hand hygiene awareness campaign for May 2021 in line with the World Health Organisation hand hygiene day
- Review IPC risk register
- Review and develop Infection Prevention and Control Group (IPCG) with reporting templates for divisional updates
- Identify and develop IPC link nurses
- Work towards an award winning service
- IPC team to commence IPC MSc
- Review the outbreak policy
- Learn lessons
- Ensure generic framework for the future.

Committee Escalation Report to the Board of Directors

Name of Committee:

People Committee

Date of Meeting:

11 November 2021

Chair of Meeting:

Paul Burstow

Significant Risks/Issues for Escalation:

- The measures in place to support staffing in Northampton were discussed including progress on the MHOST and Allocate project

Key issues/matters discussed:

- The Improvement Notice served by the HSE in May was formally closed in October. This follows the production of an improvement plan which satisfied the enforcing authority.
- The HSE investigation into the incident on Hawkins Ward in November 2020 was closed at the same time. The HSE concluded that no further action would be taken at this time.
- However, HSE are requesting that accident investigations are forwarded to them. Following the HSE Improvement Notice, the charity can expect a much closer scrutiny of how we implement our H&S arrangements.
- Leading Indicators - Active H&S monitoring activity is currently below the planned level in some areas due to H&S team capacity. Reactive monitoring is an ongoing challenge, due to team capacity and slow response to requests for information when investigating accidents
- Lagging Indicators illustrate a continued improvement YTD from 2020/21
- Staff injuries during restraint are down 18% YTD (Target is 60% EoY)
- RIDDOR reports are 37% YTD but the target of 20% EoY may be a challenge unless the recent up tick is reversed sustainably. September and October combined, 25 RIDDORs were submitted to HSE.
- A live exercise in October to test the new fire procedure received positive feedback.
- An update on the delivery of the Staffing Action Plan was provided focusing on the MHOST and Allocate roll out, a review of the Safety Nurse role, Christmas contingency planning, and a timeline for safer staffing were discussed (see appendix for the Action Plan)
- Progress against the current Volunteering Strategy was presented highlighting there are currently 320 volunteers with a further 110 joining. The Strategy will be reviewed in the light of the Board's new strategy
- The Your Voice results timescale was confirmed including a Board update on 27 January

- The Director of Learning and Development (L&D) gave a presentation on the L&D spend and impact and the Committee discussed the translation of training into practice
- People KPIs including turnover, absence, agency spend and mandatory training were reviewed. An overview of the Integrated Performance Report Matrix was shown allowing the People KPIs to be analysed against other metrics and seen at a ward level
- An annual calendar for the Committee was agreed for 22/23
- Updates were provided from the following reporting groups:
    - BENNs Group
    - Carers Group
    - Employee Forum
    - Learning & Development Group
    - Inclusion Steering Committee

Decisions made by the Committee:

- The Committee annual calendar was agreed
- It was confirmed that a Committee effectiveness review would take place for feedback at the February Committee

Implications for the Charity Risk Register or Board Assurance Framework:

- There continues to be staffing shortages within the Northampton site with the roll out of MHOST and Allocate a priority
- Health and Safety is identified as an area for ongoing monitoring with the time taken to complete accident investigations a challenge. A review of the Datix form to make it easier to complete is taking place
- Two People KPIs are below target in September: monthly sickness remains at 8% and voluntary turnover at 14%, there are a number of Nurses transferring to WorkChoice further impacting turnover
- Mandatory training is within target at 92% although ILS (74%), BLS (89%) and Safeguarding level 3 (77%) are below this

Issues/Items for referral to other Committees:

- For the L&D spend and impact item to be presented to QSC for feedback and input particularly reviewing quality assurance of learning implementation

Appendices:

- Staffing Action Plan – November progress update

Staffing Action Plan

v0.5 - Nov 21

Objective: to improve the supply of suitable skilled nursing staff (Registered Nurses and Healthcare Assistants) available to work on our wards

Ref	Open/Closed	Action	Outcome	Owner	Due Date	Overview (Nov 21)	Progress/November Outcomes
1		Maximise the availability of our permanent nursing workforce by improving the way we manage staff absence through improved data and rigorous adherence to absence policies					
1.1	Closed	Improve our management of short-term sickness absence by improving the availability, accuracy and timeliness of data relating to sickness.	Short-term absence rates consistently below 4% (overall sickness KPI is 6%)	Murtz Daud	30.09.21	01.11.21: Closed. Data available via the Integrated Performance Report and BI HR dashboard for managers to assess short term sickness cases. The Central Absence Team (CAT) review short term sickness daily and place people back on shifts via KRONOS if they have clocked in ensuring the accuracy of data. HR team working with managers to provide data relating to 'short term triggers' for absence meetings in line with the Absence Procedure to progress.	Data consistently logged via CAT team with data linking to triggers in dashboard available to managers.
1.2	Open	Improve our management of short-term sickness absence by ensuring compliance with Absence policy (all staff calling in and speaking to a manager when unwell, managers following up on sickness absences, return to work interviews etc.)	Short-term absence rates consistently below 4% (overall sickness KPI is 6%)	Nikki May	Ongoing	01.11.21: HR working closely with managers to review individual sickness cases and ensuring return to work meetings are happening. Due to the high levels of short term absence it has been difficult for managers to stay on top of this area. The Central Absence Team have supported this period by being a single contact for staff that are absent and contacting managers once an employee has reported an absence. Review of integrating the CAT and WorkChoice Coordinators currently taking place.	Review of short term absence process and procedure taking place ensuring trigger meetings are taking place when required.
1.3	Open	Improve our management of long-term sickness by ensuring compliance with the Absence policy (as detailed in 1.2, above).	Long-term sickness rates consistently below 2% (overall sickness KPI is 6%)	Nikki May	Ongoing	01.11.21: With support from the Employee Relations team, management of long-term sickness (LTS) is robust and cases are stabilising. Occupational Health review all LTS cases and support individuals to return to work where possible. Compassion focussed training is being rolled out across the Charity to support individuals wellbeing and compassionate management.	97 LTS cases in Oct compared to 89 in Sept. 14 staff returned to work in Oct. 300 staff trained on compassionate focused staff support and roll out plan being reviewed.
1.4	Closed	Improve our management of other absences by reducing the categories on kronos of available absence codes	Improved management information and tracking.	Liz Jackson	30.07.21	19.08.21: Closed. Special paid leave provision per annum moved in line with annual leave year so there is transparency across both reporting periods. Closer links to HR procedures to manage absence further and transparency for individuals on pay arrangements.	Reduction in KRONOS codes within the system from 35 to 28. A generic special Leave code was replaced by 4 more specific codes for better reporting and tracking.
1.5	Open	Improve our management of other absences by ensuring nurse managers are aware of the policy and instituting regular audits of take-up	Other (Special Paid Leave) absence rates to be consistently below 0.5%	Nikki May	31.12.21	01.11.21: Currently on track but multiple competing priorities for nurse managers might mean it takes time to embed a new approach to managing other absences. As point above, procedures are now linked to manage absence rates and to further support managers in discussions with individuals. Plans to review the recording of special paid leave so that managers are aware of levels within their teams. Currently the cut off for pay is 5 days, awareness has been communicated to line managers. This is in line with current SAP provisions and it reflects the current HR procedure. 1-1 coaching and training for managers on policy and application underway.	Other Absences Process and Procedure is being reviewed to ensure consistent management. Other absences reducing with 130 periods in Oct compared to 286 in Sept.
1.6	Open	Improve the availability of staff on wards by improving our management of staff who are considered "non-patient-facing" or who cannot undertake MAPA training	Reduced numbers of staff who cannot provide the full range of support for patients	Nikki May	31.03.22	01.11.21: OH briefed by training team around specific MAPA requirements to support assessments and recommendations. Any individuals exempt currently re-referred to OH for updated review. Review of recruitment process to ensure that physical elements are covered off during the recruitment phase and people are able to manage the MAPA provisions of the role.	88 individuals referred to OH for MAPA requirements review since April 21.
2		Maximise the availability of nursing staff by adopting a flexible approach to staffing					
2.1	Open	Offer flexible shift working to nursing staff	Increase the nursing flexible working options available to stabilise recruitment and retention. Increase the number of people working part time on the wards to 30%.	Stacey Carter	Ongoing	01.11.2021: Approach has been agreed by CEC and the plan is now in development. MHOST and Allocate roll out in progress with an internal Programme Director coordinating and project reporting to SPOG. Care homes assessment for MHOST reviewed for each ward by nursing team. Career breaks launched in April 2021 to further support flexible offer.	MHOST Establishments have been identified through data collection, validation, and clinically reviewed providing a twenty-four hour figure. This has now been socialised with Nurse Managers and agreed in all but four wards, enabling clinical teams to schedule rosters while considering changing care needs throughout the day. With the additional tools provided through the implementation of Allocate and corresponding training on effective rostering, there is improved opportunity for staff members to work a wider variety of shifts without removing the Long Day option. A Clinical and Operational Impact Assessment is underway to support further development of the operational model
2.2	Open	Introduce alternative contracts such as term time working and annualised hours				01.11.21: Adverts updated to highlight flexible working options. Recruitment continues for a new permanent 'Peripatetic' HCA team to cover required shifts across all divisions. New contract options in development.	Peripatetic HCA recruitment: 14 offered and awaiting induction and we continue to advertise and interview. Plan to recruit 40 during 21/22. Recruited 3 Staff Nurses, 1 Social Worker, 1 HCA, 1 OT, 1 DBT Therapist and 1 Consultant Psychiatrist to part-time posts since July after requests for flexibility.
2.3	Open	Return to practice, study support and extended research and/or secondment opportunities				01.11.21: In progress to support previously qualified nurses to complete their return to practice course while working with us part time. Health Education England offering funding support, paper being produced for roll out options. More blended/split roles are being advertised providing broader opportunities for research/secondments and we are actively working with hiring managers to make this more common practice.	3 blended posts advertised since 1 July 2021. 13 secondments supported since 1 July 2021.
3		Improve the availability of workchoice staff, by improving our understanding of what drives take-up of shifts, and improving support					
3.1	Closed	Undertake a consultation exercise with workchoice staff to improve our understanding of shift take-up	10% increase in the number of shifts worked by workchoice staff	Alastair Clegg	31.10.21	19.09.21: Closed. Consultation with staff complete and key theme of feedback is confidence that shifts can be completed where originally booked. Where possible we are trying to limit the movement of staff.	Review of WorkChoice model underway for review by CEC in December.
3.2	Open	Ensure all workchoice staff have clear line management arrangements and receive regular supervision	10% increase in the number of shifts worked by workchoice staff	Nikki May	31.03.22	01.11.21: This is a complex piece of work, aligning workchoice staff to Divisions and avoiding overloading the line-management responsibilities of senior nurses. They currently report into Workforce Leads. A review of the WorkChoice model is underway.	This will be included within he WorkChoice model review.
4		Improve the supply of Agency staff by ensuring rates are appropriate and that St Andrew's is a destination of choice					
4.1	Open	Undertake a review of agency rates and implement new rates as appropriate	20% increase in the number of shifts worked by Agency staff	Alex Owen	31.08.21	31.08.21: Closed. Temporary increase to agency rates in August for Nurses and HCAs to match internal incentive scheme over Summer. Short term targeted CAMHS increased rate in place contingent on volume provision from the agency.	262 agency bookings in Oct (188 via MSI) compared to 208 in Sept CAMHS (141 via MSI).
4.2	Closed	Establish regular meetings with Agencies to review take-up of shifts and identify barriers to increased shift take-up		Alastair Clegg	30.07.21	19.08.21: Closed. A first round of meetings was held with all Agencies in June and July. Barriers to be addressed include the amount of notice provided for STAH shifts, the support offered for staff new to wards, the availability of long-term block booked shifts.	Regular follow-up meetings scheduled with all Agencies to assess progress.
5		Improve workforce planning so there is a better understanding of the staffing requirement and recruitment needs					

5.1	Closed	Review current approach to setting establishment numbers and report on whether it is meeting the charity's needs	Improved understanding of recruitment challenge	Anna Williams	30.07.21	19.08.21: Closed. Review concluded that the establishment levels we recruit to are inadequate, as they do not take account of non-patient facing staff (including maternity leave), and they assume all enhanced support will be covered by overtime and bureau and agency staff. This creates an artificially low recruitment target.	New establishment method being adopted as part of the MHOST adoption.
5.2	Open	Reset recruitment and operational staffing targets and KPIs in line with revised approach to establishment levels	More accurate recruitment and staffing targets	Murtz Daud	28.02.22	01.11.21: Nursing Fill staff rate KPI updated to link to latest establishment – the roles counted within the KPI calculation as 'nursing' or available to work currently being assessed. Reviewing establishment figures in line with MHOST roll out to accurately include enhanced support.	Revised KPIs in line with the above adoption of the new MHOST approach.
5.3	Open	Growing our own' Nursing Career Family	Career development, promotion and retention of our Nursing workforce.	Martin Kersey / Andy Brogan	Ongoing	01.11.21: Ongoing investment in nursing career path including the ASPIRE Graduate Nursing Programme. Increased volume of places on Cert in Mental Health (25%). Nursing Scholarship X3 scholars introduced. First cohort of Advanced Clinical Practitioners complete in Spring 22. Introduction of a new Apprenticeship for experienced HCA's to mentor others to aid retention. The ASCEND Programme, which aims to grow non medical AC's will be an attractive career path for senior Nurses. Trainee Nursing Associate cohort advertised for 2022 start. Deputy Director of Workforce Planning working with Chief Nurse, L&D and finance to assess future focused nursing workforce plan.	150 people on or completed the ASPIRE programme. 25% increase in places for Certificate in Mental Health new selection criteria to be introduced to decrease attrition
5.4	Open	Growing Healthcare professionals of the Future in a range of professions.	Career development, promotion and retention of our clinical workforce	Martin Kersey / Andy Brogan	Ongoing	01.11.21: Over 70 people are on range of Apprenticeship programmes, offering linear and multi faceted career development. Programmes include Degrees in AHP's such as Social Work and Occupational Therapy. The enrolment of Nurse Associates and another Team Leader cohort in February will increase these numbers.	On average 14% of our workforce is promoted each year.
6		Improve retention of staff					
6.1	Open	Engagement / Wellbeing: Roll out of the Recovery & Restoration Framework which includes I) Compassion Focused Staff Support roll out ii) launch of the new strategy iii) Monthly Round Up MS Teams Q&A + Cascade iv) Your Voice Live Q&A sessions at each site v) CEC Ward visits vi) introduced career breaks and an upgraded Long Service Model	Maintain Voluntary Turnover for Nursing Staff.	Tom Bingham	31.03.22	01.11.21: Feedback obtained from Employee Forum on Recovery & Restoration Framework, number of items actioned or in progress. Your Voice live session held in across all sites and staff survey goes live goes live on 15 November with 'you said, we did' communication from previous survey actions. Long service celebration event to be held 16 September. New strategy shared on 9 September Round Up with local strategy sessions being rolled out.	6 Awards given at annual event. New long service procedure increasing milestones and voucher amount rolled out.
6.2	Open	Staffing: Engagement in new Engagement in new MHOST staffing model and new rostering system.	Maintain Voluntary Turnover for Nursing Staff.	Andy Brogan / Tom Bingham	Ongoing	01.11.21: Charity wide communication sent and an engagement team including key ward based staff is being established to develop an engagement programme. In addition to the Charity Wide Comms, key individuals from a range of areas across the Charity have attended demo sessions to improve understanding of MHOST and Allocate, as well as gain feedback to support the communication strategy. A high level plan has been developed and further steps are being taken to identify key tasks in support of developing effective communication and engaging through a range of communication channels Next step is to identify 'key influencers' in each Division and in E&F to invite them to engagement workshops in Nov and Dec. Separate demonstrations of Allocate will also take place with those who develop rotas (e.g. CNLs) and a programme of ward 'drop-ins' will also be scheduled prior to go-live.	Engagement workshops to take place in November and December.
6.3	Closed	Reward: 21/22 Pay Award to match NHS backdated to April	Maintain Voluntary Turnover for Nursing Staff.	Martin Kersey	30.09.21	01.11.21: Closed. Board approved a 3% pay review backdated to 1 April, this was paid in September.	3,763 staff received a pay increase in the Sept payroll.
6.4	Closed	Wellbeing: Increased investment in Occupational Health / Health & Wellness resource	Maintain Voluntary Turnover for Nursing Staff.	Martin Kersey	31.07.21	19.08.21: 2 x additional OH roles appointed (1 in NHT and 1 supporting Birmingham).	New roles have aided significant reduction in OH referral times and report outcomes, more focussed support to the Divisions in working with MAPA restrictions and how we can move forward on compulsory vaccinations for clinical areas.
6.5	Open	Learning & Development: A range of programmes to ensure people have the specialist skills needed to deliver care.	Maintain Voluntary Turnover for Nursing Staff.	Holly Taylor	31.12.21	01.11.21: Specialist Training Action plans in place for LD/ASD, and other divisions in progress following a pause due to Covid and course prioritisation.	Division specific action plans to be rolled out.
6.6	Open	Recognition: Ongoing implementation of CARE Awards, introduction of COVID Outstanding Contribution Awards at this year's Annual Awards Event	Maintain Voluntary Turnover for Nursing Staff.	Tom Bingham	Ongoing	01.11.21 Awards Event held across all sites in September. 21/22 CARE Awards in progress.	2,276 CARE Awards in 20/21. 100's nominated for CEC Outstanding Contribution CARE Award. Annual Award nominations: 70 Making a Difference from patients about staff. 95 Team / Ward of the Year nominations 124 nominations for 'Inspirational Individual.'
6.7	Open	Induction and reflective practice for New members of the Nurse Family	Effective induction programme for our newly qualified nurses and those new to the charity to aid retention and job performance	Dan Cox-Stone & Holly Taylor	ongoing	01.11.21: Preceptorship programme for Newly Qualified Nurses, Extended Induction programme for HCA's called the Care Certificate, updated Clinical Supervision Training to aid reflective practice and lessons learnt.	35 Nurses completed preceptorship since April 21
7		Address staffing 'hotspots' (particular wards or times of year) with targeted interventions					
7.1	Closed	Implement a pay incentive scheme to mitigate against the impact of the school summer holidays, and the potential for reduced overtime and bank shifts	Staffing levels maintained over the summer holiday period.	Martin Kersey	31.07.21	06.09.21: Closed. Scheme implemented with additional payments for overtime and (the fourth and above) bank shifts for Workchoice. Began 24 July and ends 6 September subject to review. Evidence is that an anticipated significant decline in staffing over August has been mitigated.	Incentive scheme concluded 6 September, review of targeted approach detailed in 7.1.
7.2	Closed	Produce a proposal for an incentive scheme targeting specific wards in Northampton where staffing is a particular challenge	Improved staffing on the7 wards; improved staffing elsewhere as staff are reporting reluctance to book additional shifts as they don't want to be moved to particular wards.	Alastair Clegg	31.08.21	01.11.21: Closed. Targeted incentive launched on 23rd September. Focusing on 7 of the most challenging wards. Included perm staff retention incentive over 6 month period to help stabilise the wards and create less need for movement. In addition to incentives for block booking worchoice/ overtime shifts. Initial feedback indicates the incentive has helped to increase a mutual understanding around the staffing challenges amongst nursing and MDT staff.	Incentive impact to be reviewed over 6 month period.
7.3	Open	Short term redeployment of Enabling Functions to wards where required	To supplement ward staffing as required.	Anna Williams /Ria Stanyer	Ongoing	19.08.21: Staff trained and inducted to support ward working requirements. Prioritised those with a clinical background such as within education, college and L&D team.	Limited response but on-going support being provided from Enabling Functions
7.4	Closed	CAMHS carried out listening sessions with day and night staff	140 staff were contacted	Simone Wetherall	30.08.21	01.11.21: Closed. Listening groups held across Sept and Oct with all CAMHS ward staff. Action plan developed to move forward ideas. St Andrew's are part of the CAMHS East Midlands Alliance to jointly assess workforce challenges in collaboration with NHS partners.	CAMHS workforce model review underway
8		Transform the Charity's approach to setting staffing establishments and rostering staff by adopting best practice from across the Mental Health sector					
8.1	Open	Ensure staffing levels for each ward are safe, appropriate and in line with national practice by implementing the MHOST staffing model across all Northampton wards	Staffing levels clearly benchmarked against other providers	Andy Brogan	28.02.22	01.11.21: This is a large and complex project with a Steering Group identified and project plan reporting progress to SPOG. It is included here as it is a major element of our attempts to improve our staffing position.	MHOST numbers are currently being finalised to understand the positon impacting each ward.
8.2	Open	Introduce an eRostering solution	Improved rostering systems, management information, visibility and ease of booking for staff, consistency of approach	Andy Brogan	31.08.22	01.11.21: This is being managed alongside the MHOST project to better aid staffing and the flexible shift options available.	Project in progress.

9		Ensure the Charity's recruitment activity and processes delivers the right numbers of staff more quickly to post					
9.1	Closed	Reduce the time to hire by implementing DocuSign technology for the electronic issuing of our employment offers and management of our pre-employment checking process	Speed up the employment offer and pre-employment checking process to deliver staff more quickly to post	Martin Kersey	31.08.21	01.11.21: Closed. DocuSign went live on 16.08.21 for the issuing of offer letters and employment contracts. Reference checking process being tested from 31.08.21. We will also be using the technology to provide accurate and timely internal confirmation of internal processes including internal moves and promotions which will be live by 31.12.21.	257 conditional offers sent from DocuSign since 16th August. 202 have been completed as of the 3rd November. 321 References have been sent via DocuSign since 16th September. As of the 3rd November, 152 have been completed via DocuSign & 64 outside of DocuSign.
9.2	Open	Focus on how we can further reduce our time to hire for all posts	Ensure our speed from vacancy authorisation to employee start date is a fast as possible we aim to reduced by 10 days.	Martin Kersey	31.12.21	01.11.21: COVID increased our time to hire due to the need to safely manage our induction numbers within government guidelines and at lower levels than we managed pre-pandemic. Full action plan on how to reduce time to hire being produced with close working with recruitment, HR Services, L&D. Reviewing the number of inductions offered	Conditional Offers continue to be submitted within 24 hours of receipt from Recruitment. The average time to receive the completed offer from a new starter currently sits at 4 days. Prior to DocuSign this took 10 - 12 days to receive paperwork back from new starter via post. The number of Induction spaces has recently increased and now sits at 50 spaces.
9.3	Open	Nurse pay progression to support the recruitment and retention of experienced nurses and Clinical Nurse Leads	Ensures our pay for experienced Senior Staff Nurses and Clinical Nurse Leads remains competitive in the recruitment market	Martin Kersey	01.04.22	01.11.21: First of three staggered increases went live in October 2020, the final increase goes live in April 2022 with the pay progression path communicated to all nurses.	212 Experienced SSNs received a higher than 3% increase in April 2021 or since then and 121 other SSNs received the 3% increase in September backdated to April. 86 CNLs received a higher than 3% increase in April 2021 and a further 21 other CNLS received a 3% increase in September backdated to April.
9.4	Open	Ongoing recruitment activity for Nurses. Adjust targets according to establishment levels	Achieve target for Nursing fill ratios	Dave Anthony	31.03.22	01.11.21: Physical Careers Fairs restarted post-COVID in September 2021. Attended RCN London on 9-10 September and RCNi Birmingham on 6 October. We are reviewing the RCNi and Nursing Times programme to select the most appropriate events for the New Year. University careers events are slowly restarting and we attended the University of Northampton Careers Fair on 14 October. We have restarted onsite assessment centres. We have extended our experienced nurse refer-a-friend scheme to include Nurse Manager posts.	5 Staff Nurses started in October, 21 Staff/Senior Staff Nurses started in September plus 13 ASPIRE Nurses. An additional 10 confirmed so far for Nov/Dec starts and 23 more awaiting confirmation of start date. 11 more ASPIRE Nurses graduating and starting first Staff Nurse posts in January to March 2022.
9.5	Open	Ongoing recruitment activity for HCAs. Adjust targets according to establishment levels	Achieve target for HCA fill ratios	Dave Anthony	31.03.22	01.11.21: HCA recruitment plan reviewed Sept People Committee. We have restarted onsite assessment centres. In this challenging employment market we are trying new approaches and have run a HCA campaign for Psychology graduates in Neuro resulting in 8 offers. We have shared with Medium to run a similar campaign. We are working with Andy, Dan and Anna to build a clearer understanding of future HCA needs and as MHOST and Allocate progress will be able to report back with a clear HCA recruitment plan based on care hours required.	39 HCAs started in October, 35 HCAs started in September, now 114 new HCAs in pipeline.

Committee Update Report to the Board of Directors

Name of Committee:

Nomination and Remuneration Committee

Date of Meeting:

2 November 2021

Chair of Meeting:

Stuart Richmond Watson

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- Gender Pay Gap
- Ethnicity Pay Gap

Decisions made by the Committee:

- Gender pay and ethnicity pay gap draft publication agreed to proceed to Board for approval

Implications for the Charity Risk Register or Board Assurance Framework:

- None

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- Approval of the gender and ethnicity pay gap publication to release internally and externally in Jan 2022.

Ethnicity pay report

At St Andrew's we're committed to inclusion in all its forms. We know that diversity is one of our greatest strengths and we want everyone to feel accepted and included at work. Diversity has a proven effect on our success and, most importantly, improves the care we provide for our patients.

As a charity we work hard to know how well we are doing as an inclusive organisation. As part of this we have examined the relationship between ethnicity and pay at St Andrew's. This report shares a snapshot of our pay gap as of April 2021. It shows the difference in average pay between Black, Asian and Minority Ethnic (BAME) and non-BAME groups across the organisation.

According to the ethnicity pay gap analysis:

Our median ethnicity pay gap is

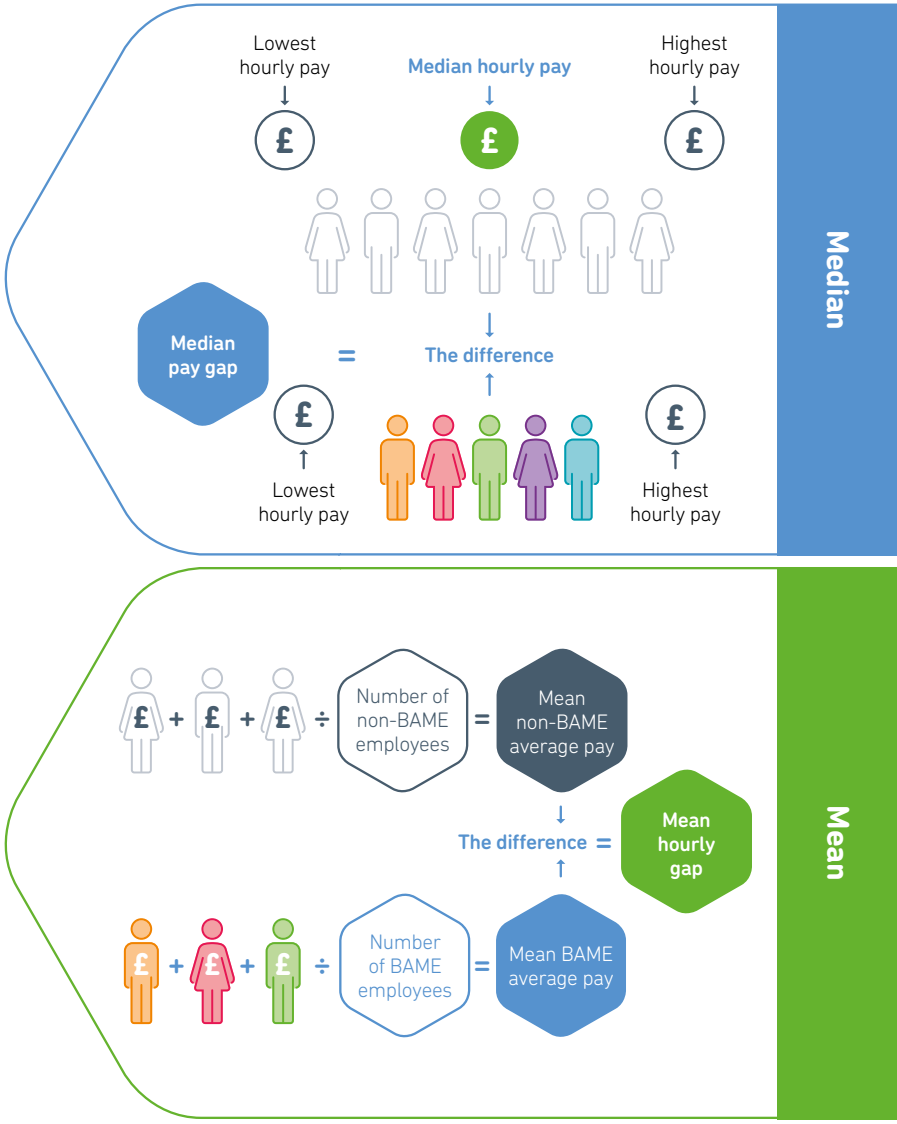
-1.9%

Our mean ethnicity pay gap is

3%

The median pay gap is the calculation that organisations focus on. We have a negative median pay gap, which means that BAME employees have a higher overall hourly rate when compared to non-BAME employees. Due to the way it is calculated the mean is slightly higher, however this is still below the national average.

This is very positive compared with the national average; the 2020 national ethnicity median pay gap is 2.3%, which means that generally across the UK non-BAME employees are paid more than BAME employees.



The calculations are based on an ethnicity disclosure of **68%**.

Pay data

Difference between gross hourly earnings for BAME employees	Median middle		Mean average	
	2021	2020	2021	2020
Asian	-3.6%	-7.7%	-36.7%	-33.7%
Black	-2%	-4%	10.2%	12.2%
Mixed	1.7%	4.4%	1%	1.3%
Other Ethnicity	-0.9%	-5.2%	-9.1%	-3.7%
Overall BAME	**-1.9%**	**-3.9%**	**3%**	**4.2%**

Pay quartiles

	Lower quartile	Lower middle quartile	Upper middle quartile	Upper quartile	Overall
Non-BAME 2021	**69%**	**59%**	**59%**	**61%**	**62%**
Non-BAME 2020	69%	67%	63%	66%	66%
BAME 2021	**31%**	**41%**	**41%**	**39%**	**38%**
BAME 2020	31%	33%	37%	34%	34%

St Andrew's HEALTHCARE

What are we doing?

We are committed to creating a highly inclusive working environment for all, and we have a number of initiatives underway to support this, including:

- **A charity wide employee focused diversity and inclusion strategy**
- **Continued monitoring of all recruitment and reward decisions from an ethnicity perspective to ensure that our processes are free from bias;**
- **Extending a reverse mentoring programme pairing BAME network members with leaders from within the Charity Executive Committee**
- **A charity wide anti-racism campaign**

We confirm that the information and data reported is accurate as of the snapshot date of 5 April 2021.

Katie Fisher, Chief Executive

Martin Kersey, Executive HR Director

Gender pay report

At St Andrew's we're committed to inclusion in all its forms. We know that diversity is one of our greatest strengths, contributing positively to our success and, most importantly, to the care we provide for our patients.

This gender pay report is prepared according to the legislative requirements for organisations with more than 250 employees and shares a snapshot of our pay gap as of April 2021. It shows the difference in average pay between men and women across the whole charity. It does not measure equal pay, which relates to what women and men are paid for the same or similar jobs, or work of equal value.

In the fifth year of publication we have continued to perform ahead of other organisations.

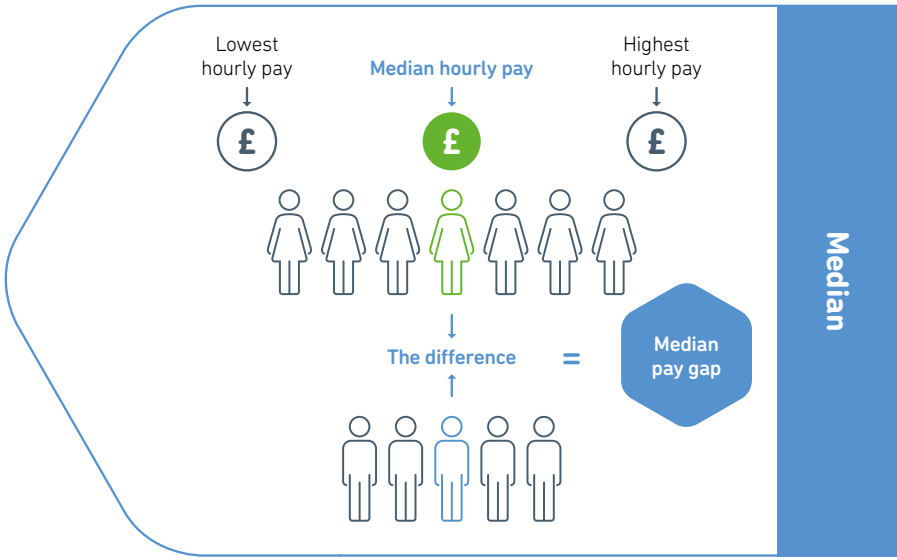
According to the gender pay gap analysis:

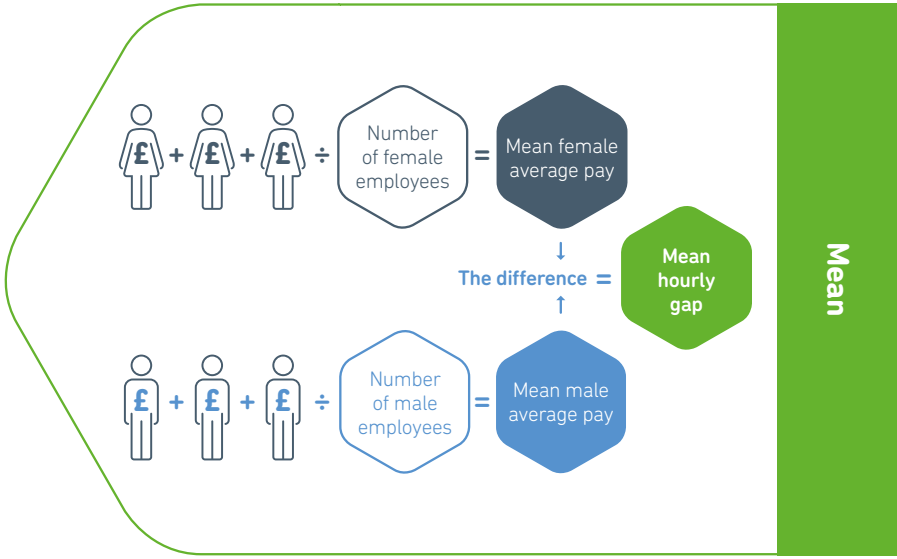
Our **median** gender pay gap is **2%**, this means there is a 2% difference between our median male and female hourly rates, when taking into account total remuneration. This year has seen an increase in males completing shifts which attract unsociable hours payments.

Our **mean** gender pay gap increased slightly from 7% to **9%**, this is well below the national average.

We are continuing in our efforts to pay fairly and equally and to improve pay for lower earners whilst exercising pay restraint at senior levels.

We're confident in the actions we take to promote and sustain inclusion, in our robust pay governance and our commitment to our reward strategy for all employees.





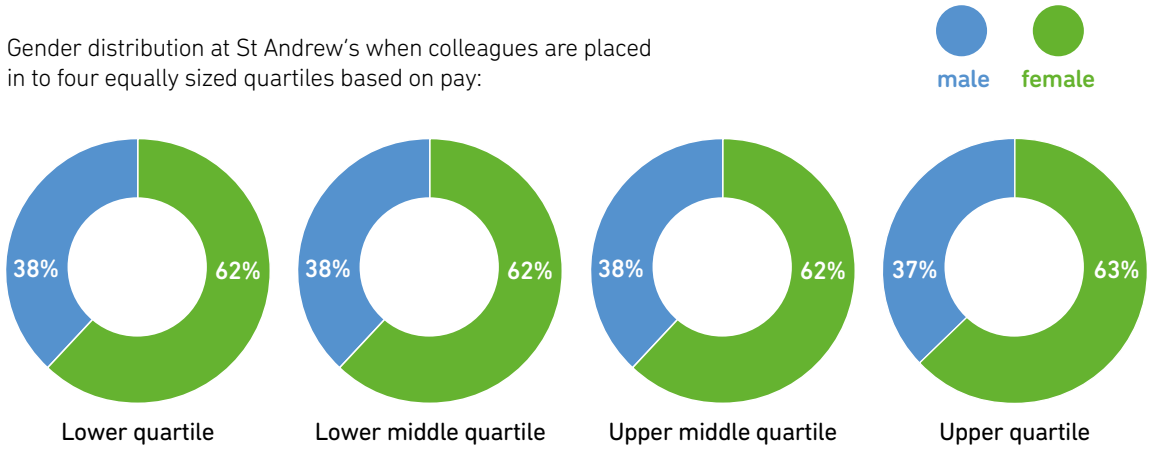
Pay data

Difference between gross hourly earnings for men and women	Median middle			Mean average		
	2021	2020	2019	2021	2020	2019
St Andrew's Healthcare	2%	0%	0%	9%	7%	7%
National	12%[1]	16%	17%	14%[2]	15%	16%

	Lower quartile	Lower middle quartile	Upper middle quartile	Upper quartile	Overall
Male – 2021	33%	38%	40%	37%	**38%**
Female – 2021	67%	62%	60%	63%	**62%**

Pay quartiles

Gender distribution at St Andrew's when colleagues are placed in to four equally sized quartiles based on pay:



1. Average from all reports to Government Portal up to 30th September 2021. Final figure not yet published
2. Average from all reports to Government Portal up to 30th September 2021. Final figure not yet published

St Andrew's HEALTHCARE

To ensure we make good people decisions based on merit, we continue to practice values based recruitment, gender analysis of performance ratings, talent management and balanced gender diversity requirements for senior role shortlists.

In addition to this we have an Inclusion Strategy, of which a key priority is to improve female representation.

To achieve this we are continuing with a series of Diverse recruitment panels that include:

- The roll out of unconscious bias training
- An extension of the Director development programme where over 80% of leaders are female
- Continuing support for WISH staff network (Women in St Andrew's Healthcare)
- Mentoring and coaching programmes for senior leaders

The positive results we have seen in this area are something we are very proud of.

We confirm that the information and data reported is accurate as of the snapshot date 5 April 2021.

Katie Fisher, Chief Executive

Martin Kersey, Executive Director of HR

Paper for Board of Directors	
Topic	Integrated Quality Performance Report (previously Performance Report)
Date of Meeting	Thursday, 25 November 2021
Agenda Item	**10**
Author	Alex Owen (CFO – authored the finance update) and Anna Williams (Director of Performance)
Responsible Executive	John Clarke
Discussed at Previous Board Meeting	Routine paper with a refreshed approach. This specific version has not been previously discussed.
Patient and Carer Involvement	Patients and Carers have not been directly involved in this paper. The voice of those we work with will be included as part of Prems. Insight gained from Prems will be used to inform the measures included within the Integrated Quality and Performance Report.
Staff Involvement	Staff have not been involved in this paper. The voice of staff will be included via the outputs of Your Voice and a proposed experience / morale metric that is more frequent.
Report Purpose	Review and comment ☒ Information ☐ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	The quality and patient experience elements of the report have been considered and discussed in detail at QSC. The workforce elements at People Committee and the Finance elements will be discussed at FinCom.
Report Summary and Key Points to Note	

This report has been refreshed to more closely align with the Charity's focus on quality.

In addition feedback from Executive and Non-Executive Directors has been incorporated in the refreshed approach. The reporting improvements will be iterative and responsive to refinement feedback. The improvements include: a scorecard format, an example of an expanded scorecard considering both variation and assurance, the plan to introduce benchmarked targets with thresholds, moving to an exception reporting approach and the introduction of forecasts.

Summary of October

- Quality improvement remains in significant focus – whilst at a Charity level there are no special cause concerns, this does not align with the commitment to improvement, work is on-going and benchmarking insights are to be utilised in the future in order to ascertain the areas for comparative improvement.
- Workforce challenges persist – there are multifaceted plans in place to address the challenges. From a nursing perspective the new patient facing model MHOST and the complimentary eRostering roll out are core. Alongside this is a broader focus on workforce planning, culture, wellbeing and morale improvement.
- Financial outturn is marginally ahead of the reforecast. Unrealised movements in investments have been accounted for in line with the pre-agreed approach.

Feedback on the adaptations to this report are most welcome. Iterative improvements will continue to be presented.

Appendices

St Andrew's Healthcare Integrated Quality Performance Report

November 2021

Quality first ethos

The Charity is committed to improving quality.

In order to provide greater visibility of quality, and the associated supporting activities that combine to deliver recovery and quality outcomes for all the people we support, every day – this report is changing.

The metrics in the Integrated Quality Performance Report are being expanded to ensure completeness. The addition of benchmarked informed targets will enable the identification of areas of comparative improvement requirement.

This version of the report presents the planned reporting improvements in more detail and then works through each one in turn. For each reporting improvement this paper shares more about the approach and shows the October outturn through that lens.

These improvements will be iterative and responsive to feedback.

Iterative reporting improvements There is a mutual desire, across the Non-Executive and Executive Board members, to improve reporting. The dual aim being to ensure all the key metrics that combine to drive quality are being presented and reviewed, with the review being informed by both variation and assurance.

Planned improvements	Timescale
1) Scorecard approach – provide the ability to see key metric, quality and enabling, at a glance.	Initial version presented within this report. Iterative improvements for January report.
2) Expanded scorecard – assessing metrics against two dimensions 1) variation (SPC) and 2) assurance (targets).	Subset example provided within this report, for the workforce KPIs. January, full scorecard in this format.
3) Variation – in addition to SPC, rolling averages and comparative means to be presented to aid assessment of trends.	Example six month rolling averages provided in this report. Capability to be built into dashboards, focus trends available for January report.
4) Assurance – where appropriate, targets to be determined with sub-committees, targets to be informed by benchmarking insight.	Benchmarking insight being shared January Board. Agreed targets to be in place to commence 22/23.
5) Exception based reporting – metrics, favourable or adverse, for variation or assurance, will be highlighted and the accountable Executive will provide causal analysis and (for adverse variances) remedial actions and/or mitigations, with planned dates for exception reversal. Creating a tailoring to issues approach.	Exception reporting commencing from this report. Iterative improvements to follow in subsequent reports.
6) Forecasting – developing forecasting capability for key metrics, to enable trajectories to be plotted.	Example presented in this report. Development priority order to be agreed with sub-committees.

1) Scorecard approach

Scorecard October 2021 the below scorecard presents the existing key metrics from an SPC perspective (already within the Integrated Quality Performance dashboard). The metrics are in the process of being expanded to include further outcome measurers, alongside leading quality indicators and PREMs. Providing greater visibility of quality, in order to target interventions.

Charity Position

-	Incident	Violence	Incident L1	Incident L2	Incident L3	SI	Restraint	Seclusion	LTS	ES Episodes	ES WTE	Vol Turnover	Training	Sickness %
StAndrews														

Divisions

-	Incident	Violence	Incident L1	Incident L2	Incident L3	SI	Restraint	Seclusion	LTS	ES Episodes	ES WTE	Vol Turnover	Training	Sickness %
Neuro														
MS														
LSSR														
Essex														
ComServ														
CAMHS														
Bham														
ASDLD														

Statistical Process Control (SPC) rule trigger icons. Hover over icon for more info

Concerns Improvements In Control

Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns Improvements

2) Expanded scorecard

Expanded scorecard to include assurance targets the below scorecard uses the workforce metrics for October, to show an example of the future direction, where variations and assurance are side by side.

Charity Position

Measure	Vol Turnover		Vol Turnover Month		Training		Sickness		Sickness Covid		Sickness Non Covid		Agency Spend		Sickness %	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
StAndrews	H	F		P	H	P	H	F	L		H		L	P		F

Divisions

Measure	Vol Turnover		Vol Turnover Month		Training		Sickness		Sickness Covid		Sickness Non Covid		Agency Spend		Sickness %	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
ASDLD	H	P		F	H	P	H	F	L		H		L	P		F
Bham	H	F		P	H	P	H	P					L	P		P
CAMHS	L	F		P	H	F	H	F			H			F		F
Essex	H	F		F		P	H	F	L		H			F		P
LSSR		F		P		P	H	F	L		H		L	P		F
MS	H	F	↘	P		P	H	F			H		L	P		F
Neuro		P	↗	F	H	P	H	F	L		H			P		F

Statistical Process Control (SPC) rule trigger icons. Hover over icon for more info

Concerns H L Improvements H L In Control

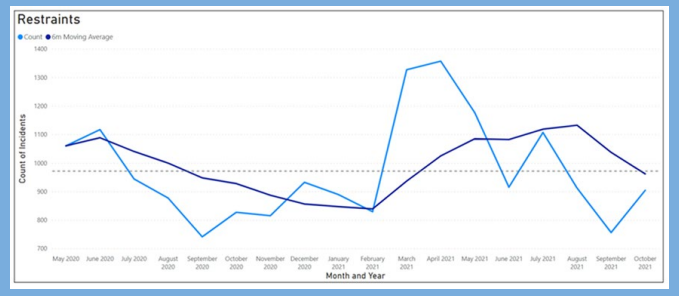
Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns ↘ ↗ Improvements ↘ ↗

3) Variation

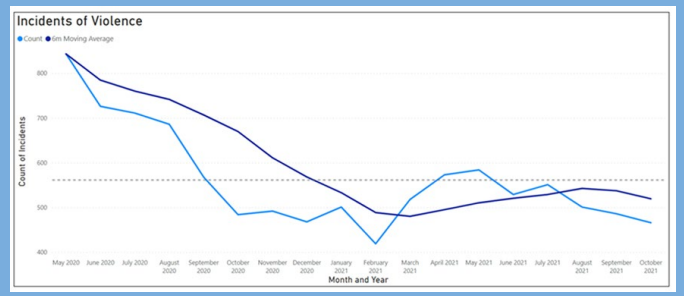
Variation Rolling averages provide an alterative approach to assessing trends. Utilising shorter timescales means that, whilst not statistically significant, trends can be highlighted – allowing for swift awareness, assessment and action. Examples presented below are counts at a Charity level, OBD charts will be presented in future.

Restraints



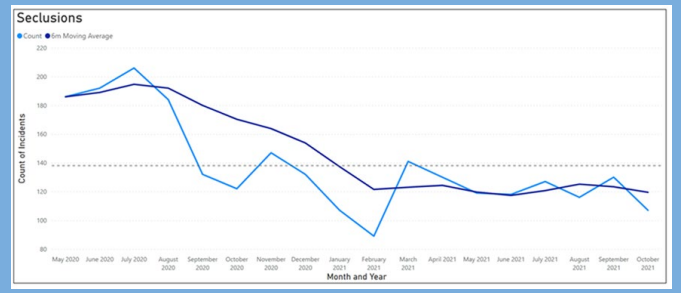
Restraints show no special cause variation. The rolling average demonstrates a trend of increasing restraints in the Spring 2021, followed by reductions. In advance of the OBD chart, the reduction in restraints is marginally ahead of the reduction in occupancy.

Incidents of Violence



Incidents of violence show no special cause variation. The rolling average demonstrates a decreasing trend that has largely plateaued. In advance of the OBD chart, the reduction in incidents of violence is ahead of the occupancy fluctuation.

Seclusions

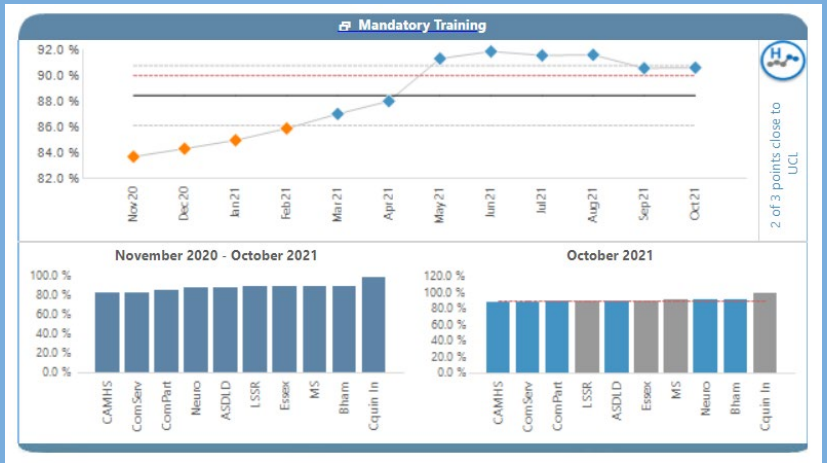


Seclusion episodes show no special cause variation. The rolling average demonstrates a decreasing trend that has largely plateaued in 2021. In advance of the OBD chart, the reduction in seclusions is ahead of the occupancy fluctuation.

4) Assurance

Assurance Targets to be determined for quality metrics. Targets to be informed by internal context from trends, internal forecasting considerations, plus external context provided by benchmarking insights. Targets to be agreed with sub-committees.

Thresholds to be developed for targets to ensure that the scorecard flags metrics that are close to breaching a target.



Mandatory training is a good example of the need for thresholds. The SPC is showing a special cause improvement – with the recent months being ahead of the mean. The scorecard would also show as favourable for assurance, given the metric is above target. That said, forecast assurance must be considered to be limited, due to the proximity of the metric to the target. In such circumstances, it would be appropriate to present actions being taken to mitigate a breach of target. With this in mind thresholds will be developed for all targets. Causal analysis, context and remedial actions for mandatory training are provided in the exception reporting below.

5) Exception report

Exception report based on the Charity position at the end of October 2021. Across the existing metrics, there are four areas of special cause improvement and one of special cause concern. In addition two areas are shared due to breach of, or proximity to, target.

Charity Position

Establishment fill rate metrics

The proportion of registered nurses employed compared to the planned establishment has not been shared, as the planned establishment is being rebased with the introduction MHOST and the current approach is not comparable.

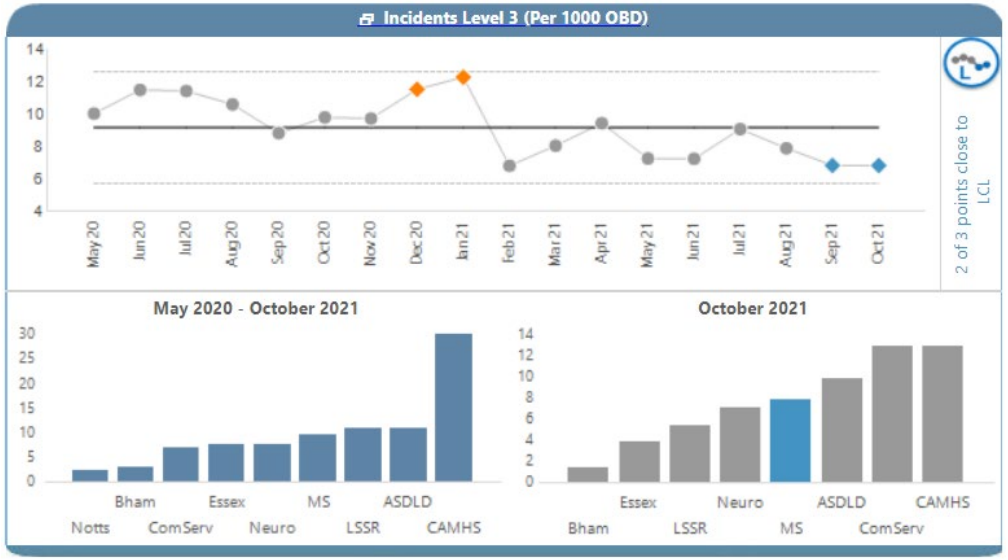
MHOST will be presented to the January Board. The embedding of this new patient facing staffing model will be supported by a new workforce model, with a focus on offering greater flexibility to existing staff and offering new options to potential recruits. Getting the right staff, in the right place, at the right time will be further enabled by incoming the eRostering solution. Additionally, on going cultural enhancement and alignment will be prioritised to support the experience of employees, the quality of services and the delivery of the strategy.

Quality first ethos as mentioned above, the metrics in the Integrated Quality Performance Report are being expanded, as the current suite of metrics is incomplete. The addition of benchmarked informed targets will readily enable the identification of areas of comparative improvement requirement, particularly pertinent for areas of common cause variation and assessing additional improvement should be a focus for an areas of special cause improvement.

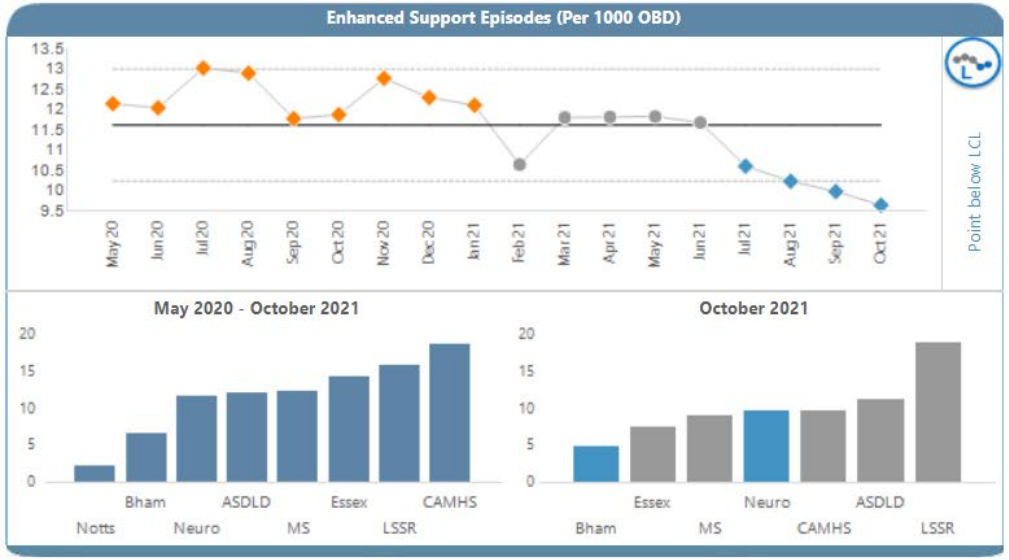
5) November Exception report (October data)

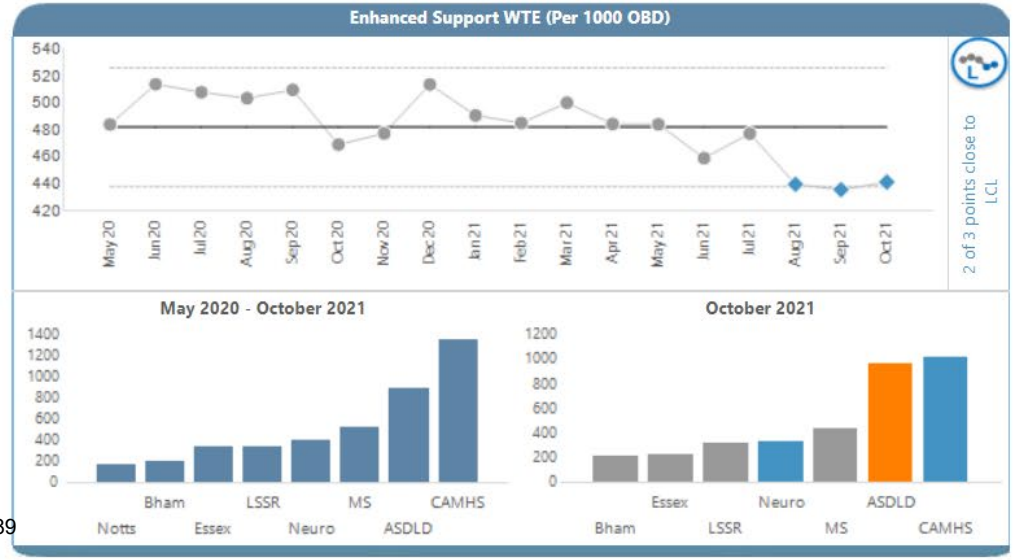
Exception reporting – Quality Level 3 Incident and Enhanced Support

Improvements



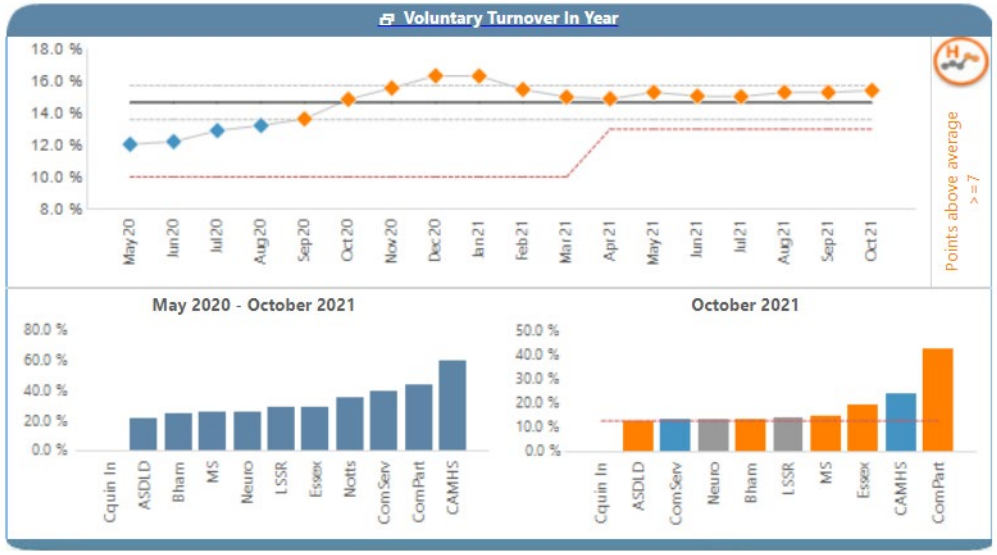
Special Cause Variation - quality improvements are evident in the reduced occurrences of level 3 incidents (without corresponding increases in other levels) and fewer new episodes of enhanced support, correlating with a reduction in the level of resource required to facilitate enhanced support. Going forward metrics with targets will give context to SPC variations.

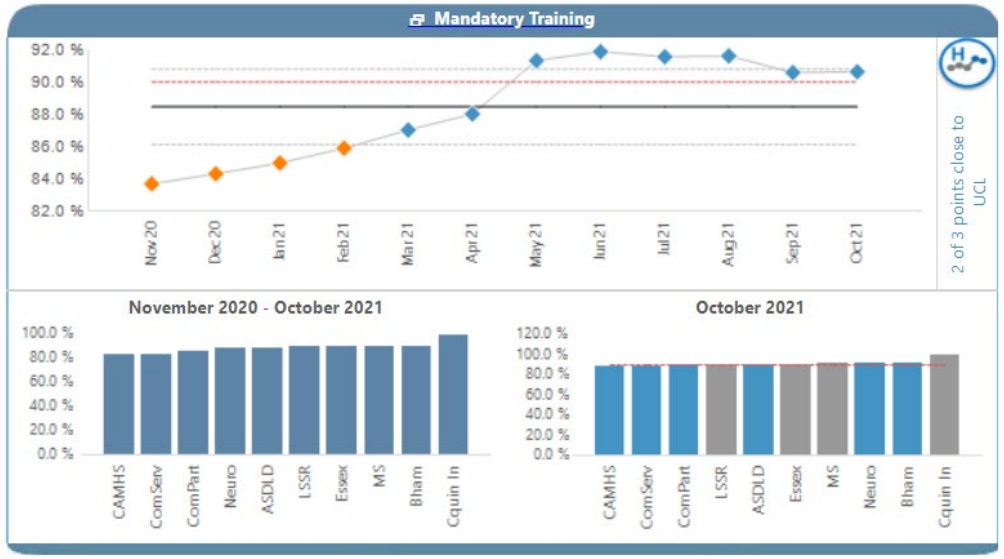




Exception reporting – Voluntary turnover & Mandatory training (due to target proximity)

Concerns
Improvements

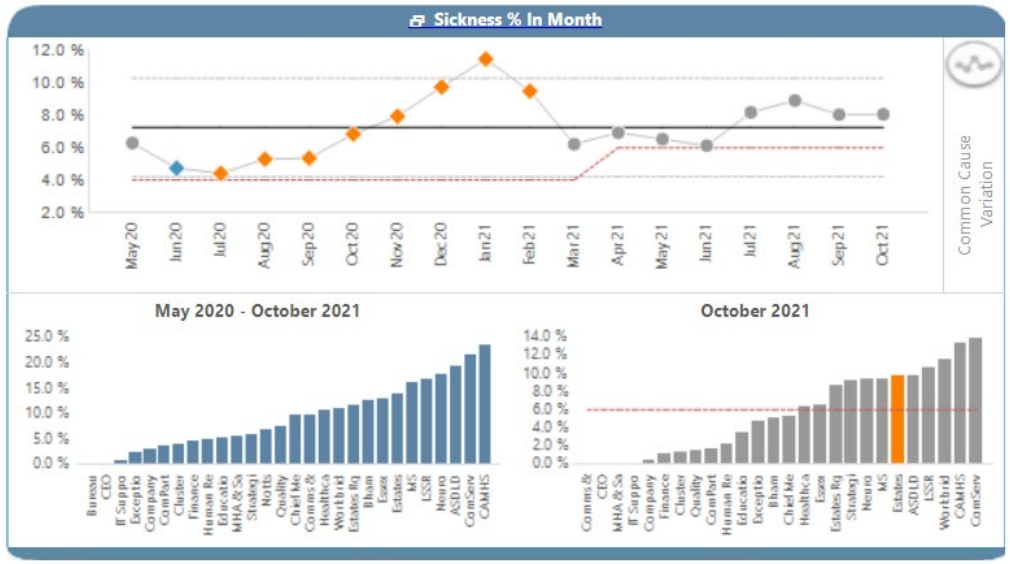




Causal analysis – registered nurses and medics are two critical roles with higher voluntary turnover. The main reasons for RNs leaving the Charity are promotion and work life balance. For medics predominately, work life balance. **Context** – benchmarked turnover rates comparable with NHS. **Remedial actions** – nursing workforce model and clinical flexible working options being progressed. Alongside whole staff wellbeing focus and talent management review.

Causal analysis – training levels fell during the pandemic, releasing staff from clinical duties to attend training, at the pace required to catch up, has been hampered by staffing challenges. ILS, BLS and safeguarding are below target. **Context** – **recent benchmarked NHS training levels are 65 – 80%.** **Remedial actions** – innovative delivery solutions, new nursing model and the launch of a Clinical Hub supporting training attendance.

Exception reporting – Sickness (due to target breach)



Reported sickness category	%
Cold, cough and flu	15%
Covid 19	12%
Gastro-intestinal	12%
Anxiety, stress and depression	10%

Whilst sickness shows no special cause variation, it is in excess of target and the impact of absence remains significant for the Charity. Recent positive reductions in long term absence have been offset by increased short term absence levels. Refreshed benchmarking can be undertaken with the next release of sickness data from NHS digital – due 25.11

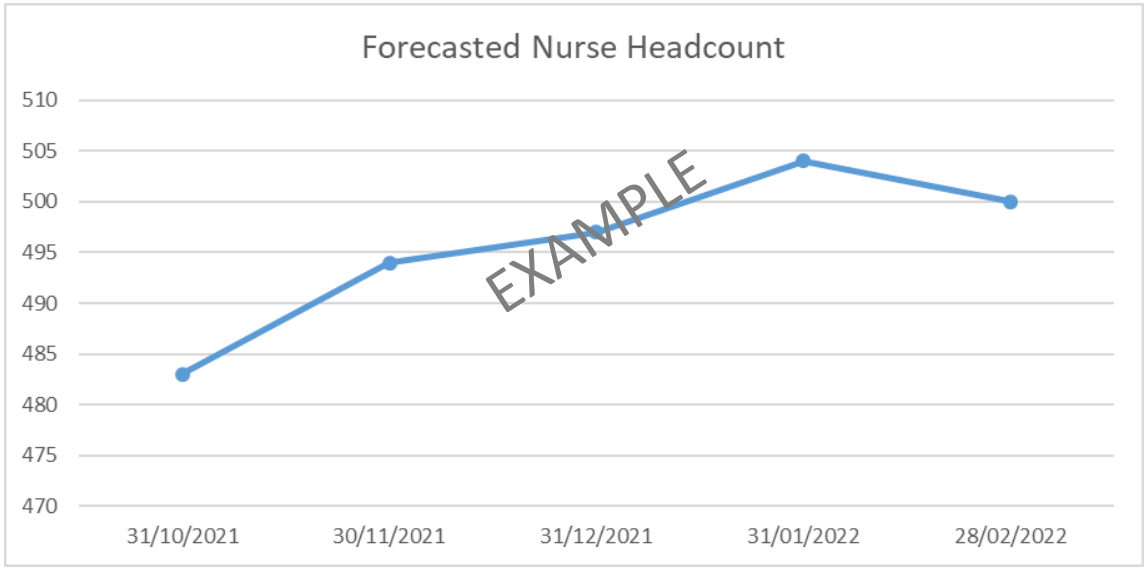
Remedial actions – the staffing action plan reviewed at People Committee includes a focus on absence management, the continued roll out of Covid booster vaccination and flu vaccination programme will support the top two absence categories,

case management of all long term absence cases by the Employee Relations team continues, alongside the broader focus on short term absence management and wellbeing.

5) Forecasting

Forecasting for key metrics provides visibility of the likely trajectory and in turn an alternative aspect of assurance. The Charity needs to build capability in this area. Initial focus has been applied to workforce metrics, given the prevailing challenges and the link between staffing capacity, confidence, capability and quality outcomes for the people we support.

Example forecast approach – draft registered nursing headcount forecast



This is very much a first draft – further layers of analysis are required to refine this forecast before it could be used with confidence. The draft forecast starts with the end of October headcount, and applies a monthly attrition assumption (based on the previous 12mth average) and offsets this with the number of incoming staff within the pipeline who have a conditional offer. Refinements are needed to take account: transfers between flexible and permanent workforce, transitions from newly qualified nurse to staff nurse and the rolling conversion percentage from conditional offer to role commencement.

Summary

- **Quality –** this report is evolving to more closely align with the Charity's focus on quality.
- The **right metrics** will be presented, with analysis informed by **variation** and quantified in relation to a benchmark informed **target**. Reporting will be by **exception**, enabling a tailored to issues approach.
- Current quality and performance – the recovery and quality outcome commitments, made to the people supported by St Andrew's Healthcare, are enabled by the workforce. Integral to the quality of care is the experience of the whole team who are part of providing it. St Andrew's Healthcare is committed to providing a rewarding and safe place to work. This report highlights workforce challenges and the associated headline actions being undertaken to improve wellbeing and support progress towards a thriving workforce. A workforce that is confident, competent and motivated to provide quality care.

Finance overview

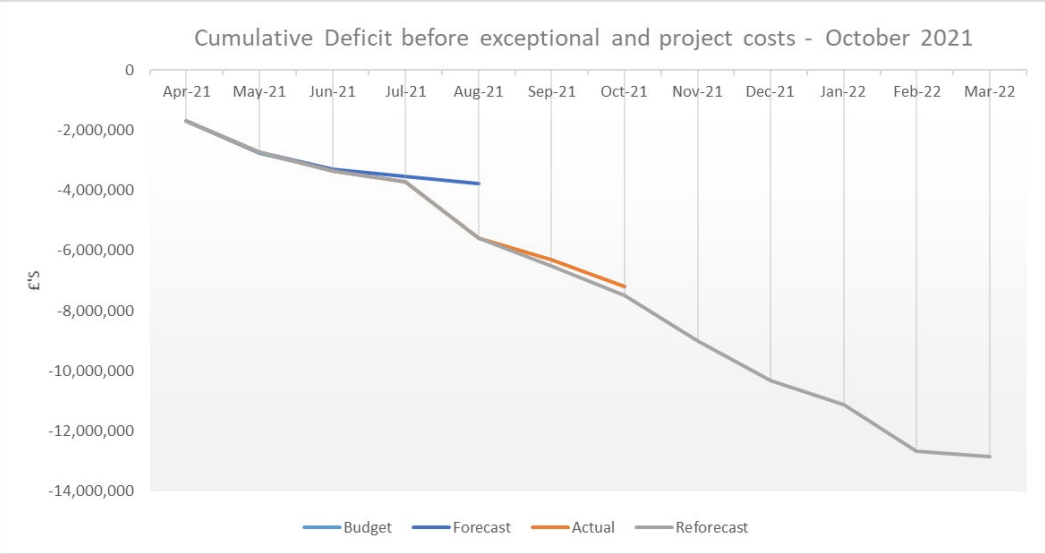
Finance overview

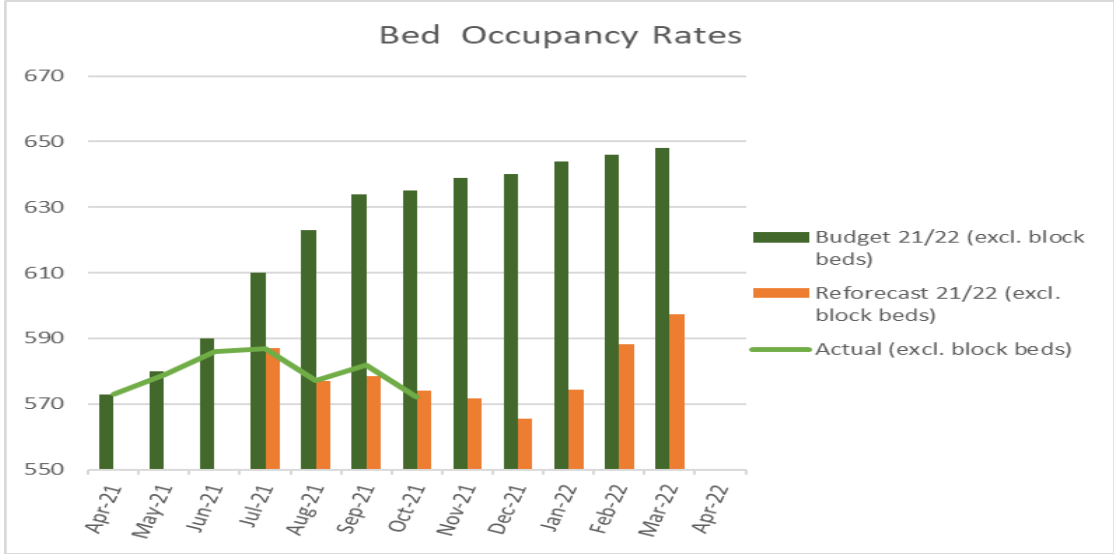
Commentary
Operating surplus and Net surplus positions are marginally ahead of the reforecast financial position. As previously discussed the financial position continues to be impacted by the restrictions on admissions due to staff levels and Covid restrictions etc. and other factors, all of these have been reflected within the reforecast position presented to the Board in the September meeting – Performance on all key budget lines is in line with expectations with the exception of Indirect costs which relates to an overspend in MDT spent mainly across low secure and ASD/LD services where MDT levels have either not reduced as a result of short-term closure of a ward or have been increased in anticipation of a ward opening. These overspends are being monitored closely and are expected to resolve themselves in the next quarter.
The staffing challenges that the Charity experienced over the summer remain and as a result of the lower staffing levels we have seen an underspend against reforecast for the last 2 months.. Over the coming months we will monitor the impact of the targeted incentive scheme to ensure we are realising the benefits on those wards where staffing is the most challenging. As referenced above, the combination of MHOST and eRostering will support improvement in staffing.
Occupancy is in line with the expectations set out in the reforecast. - we continue to meet with divisional colleagues on a monthly basis to review occupancy and predict future months activity, weekly meetings with the CQC will be held to approve admissions to the 14 remaining wards subject to enhanced monitoring.
We have accounted for the unrealised movement in the Smith and Williamson investment portfolio in line with expectation at the end of Quarter 2 - As agreed at the start of the year we review the investment portfolio on a quarterly basis only adjusting for the movement if it is considered material, in the reforecast we had made the assumption that we would account for the unrealised gain/losses at the end of the second quarter, the actual position at the end of October 2021 is marginally different from the reforecast assumption but is not a significant variance.

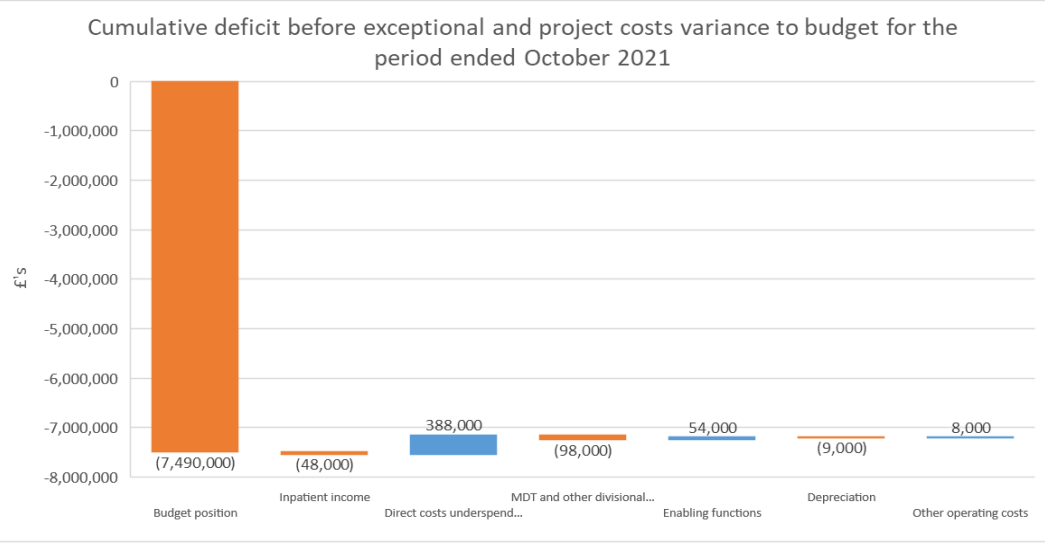
St Andrew's Healthcare – Board Performance Report

October 2021

Finance snapshot







Cashflow summary to October 2021	(£'m)
Opening cash position at 1/4/2021*	(14.0)
YTD Capex expenditure	(1.1)
YTD working capital movements	(3.5)
YTD net deficit	(7.1)
YTD Depreciation	8.2
Closing cash position at 31/10/2021*	(17.5)
YTD Capex expenditure	(0.9)
YTD working capital movements	(2.6)
YTD net deficit	(7.3)
YTD Depreciation	5.3
Reforecast closing cash position at 31/03/2022*	(23.0)

** Excludes stock market Investments*

St Andrew's Healthcare – Board Performance Report

October 2021

Finance update

	Oct 2021 MTD			Oct 2021 YTD		
	Oct 2021 MTD Actual	Reforecast	Variance to Reforecast	Oct 2021 YTD Actual	Reforecast	Variance to Reforecast
Available beds	695	700	(5)	697	698	(1)
Occupied beds	572	574	(2)	579	579	0
Occupancy %	82.3%	82.0%	0.3%	83.1%	83.0%	0.1%
Total Income (£'000)	**13,184**	**13,283**	**(99)**	**93,870**	**93,918**	**(48)**
Total Direct costs	(6,716)	(7,030)	314	(48,869)	(49,257)	388
Gross surplus (£'000)	**6,468**	**6,253**	**215**	**45,001**	**44,661**	**340**
Total Indirect costs	(3,640)	(3,553)	(87)	(25,649)	(25,552)	(97)
Net Contribution (£'000)	**2,828**	**2,700**	**128**	**19,352**	**19,109**	**243**
Enabling functions (£'000)	(2,436)	(2,432)	(4)	(17,820)	(17,874)	54
Depreciation (£'000)	(1,142)	(1,136)	(6)	(8,148)	(8,139)	(9)
Operating Surplus/(Deficit) (£'000)	**(750)**	**(868)**	**118**	**(6,616)**	**(6,904)**	**288**
Non-operating costs (£'000)	(129)	(120)	(9)	(578)	(585)	7
Exceptional costs (£'000)	(156)	(148)	(8)	(520)	(494)	(26)
Project costs (£'000)	(180)	(180)	0	(180)	(180)	0
Disposal of Fixed Assets & Impairment	(158)	(198)	40	(755)	(808)	53
Unrealised Movement on investments (£'000)	1,546	1,593	(47)	1,546	1,593	(47)
Net Surplus/(Deficit) (£'000)	**173**	**79**	**94**	**(7,103)**	**(7,378)**	**275**

St Andrew's Consolidated Balance	Mar-21 Audited	Oct-21 Actual
	£M	£M
Intangible and tangible fixed assets	209.0	201.9
Investments		
Stock market investments	15.7	17.5
Investment properties	5.7	5.7
Current Assets		
Stock	0.6	0.5
Trade debtors	7.3	9.4
Other debtors & Accrued Income	5.2	5.3
Prepayments	1.7	1.6
Cash	5.8	7.4
	20.6	**24.1**
Current Liabilities		
Trade Creditors	(7.6)	(6.6)
Taxation and social security	(3.1)	(3.1)
Other creditors & Accruals	(8.5)	(9.2)
Staff Accruals	(4.0)	(3.7)
Deferred Income	(2.5)	(3.6)
	(25.7)	(26.1)
Net Current Assets/(Liabilities)	**(5.2)**	**(2.0)**
Total Assets Less Current Liabilities	225.2	223.2
Bank Loans (between 1 and 5 years)	(19.8)	(24.9)
Pension Scheme Liability	(0.7)	(0.7)
Total Assets Employed	204.7	197.6
Reserves	204.7	197.6

IT Security overview

IT Security Metrics - October 2021

Legend: No Change | Trending Down | Trending Up

	AUG	SEPT	OCT	RAG	October Causal	October Remediation
Vulnerabilities not fixed within SLA Highlights the amount of infrastructure vulnerabilities that haven't been fixed within the agreed timescales	22	7	5		**Causal Analysis**: The 5 medium vulnerabilities relate to a required upgrade of a service on a reporting server and weren't fixed in time due to capacity and workload constraints. They were not the same vulnerabilities from September.	**Remedial Actions:** A non-conformance was raised against the responsible owner. They have since requested a dispensation for 2 months as the vulnerabilities need to be investigated with the supplier. These vulnerabilities are on an internal server.
Overdue Penetration Test Remediations The last Pen test for the Charity was in July 2021. This highlights how many findings are overdue.	0	0	0		**Causal Analysis**: No overdue actions again this month.	**Remedial Actions:** IT Security will continue to monitor the remediations and co-ordinate their resolution.
Security Incidents Trend of Priority 1, Priority 2 and Priority 3 incidents	P1 0 P2 0 P3 15	P1 0 P2 1 P3 8	P1 0 P2 2 P3 7		**Causal Analysis**: All incidents in October related to phishing attacks. An increase in P2 incidents this month whereby staff clicked on malicious links within phishing emails, but the links were blocked by the web filter.	**Remedial Actions:** IT Security are reviewing the current phishing awareness methods as a multi-pronged approach is required. 1:1 conversations with staff who click on links have been implemented to provide more targeted awareness as well.
Mitigated Network Attacks These are blocked network attacks directed at our external network edge	5,859	6,329	6,256		**Causal Analysis**: We are constantly being port scanned and probed by external threat actors. Our firewall is configured to block this traffic.	**Remedial Actions:** Whilst these are mitigated attacks and are within the expected level for the month, the IT Sec team have performed a firewall rule audit this month to ensure the configuration is appropriate.
Overdue IT Sec Audit Actions Number audit actions and their rating from scheduled internal and external audits.	2	7	0		**Causal Analysis**: There were a number of audit actions that were overdue that IT Security have been engaging with the responsible owners to get resolved. A lack of priority and focus was evident.	**Remedial Actions:** Steps will be put in place to ensure regular catch ups with audit action owners to ensure the actions continue to get the right level of visibility and priority.
Outstanding Operating System Patches % of devices patched across the infrastructure. Separated into server and endpoint estate	Servers = 91 % Client = 84 %	Servers = 87 % Client = 87 %	Servers = 98 % Client = 85 %		**Causal Analysis**: An average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc). Client devices are all built to a government secure industry standard, have anti-malware installed, are protected by the web filter even off the network and have firewalls enabled	**Remedial Actions:** The patching process for client devices is due to be reviewed with more staff working remotely or not being based in an office which causes some delays e.g. Community Partnerships.
Anti-Malware Installation Compliance % of machines on the network that have anti-malware protection installed and enabled	100 %	100 %	97 %		**Causal Analysis**: 3 servers were reporting as not having anti-malware installed. Either the agent hasn't installed correctly or has stopped communicating back to the management server	**Remedial Actions:** The system engineers are re-deploying the agent onto these machines. One server is already resolved, with the other 2 due imminently.
Mitigated Attacks on Staff Accounts Attempted logins from malicious actors to staff accounts. These aren't successful and are flagged by our SIEM tool	27	21	34		**Causal Analysis**: Attackers perform password attacks against accounts they find on Linkedin or through other means. They will use 1000s of common passwords through automated tools. Finance is the most targeted department per ratio of 100 staff	**Remedial Actions:** IT Security monitor these on a daily basis and will investigate to ensure they are not successful. High risk departments have Multi-Factor Authentication enabled e.g. Finance, HR, IT, Estates.
Security Awareness % of applicable staff who have completed their e-learning module on cyber security & information governance	92 %	92 %	93 %	100	**Causal Analysis**: Increase of staff who have completed their mandatory training this month, but still not at the required level of 95% for the Data Security & Protection Toolkit.	**Remedial Actions:** IT Sec & Info Gov have revised the training and are looking to have different training courses for different job roles to ensure staff are getting the right information at the right level. Currently with L&D to implement.

Navigating St Andrew's SPC charts

Target line

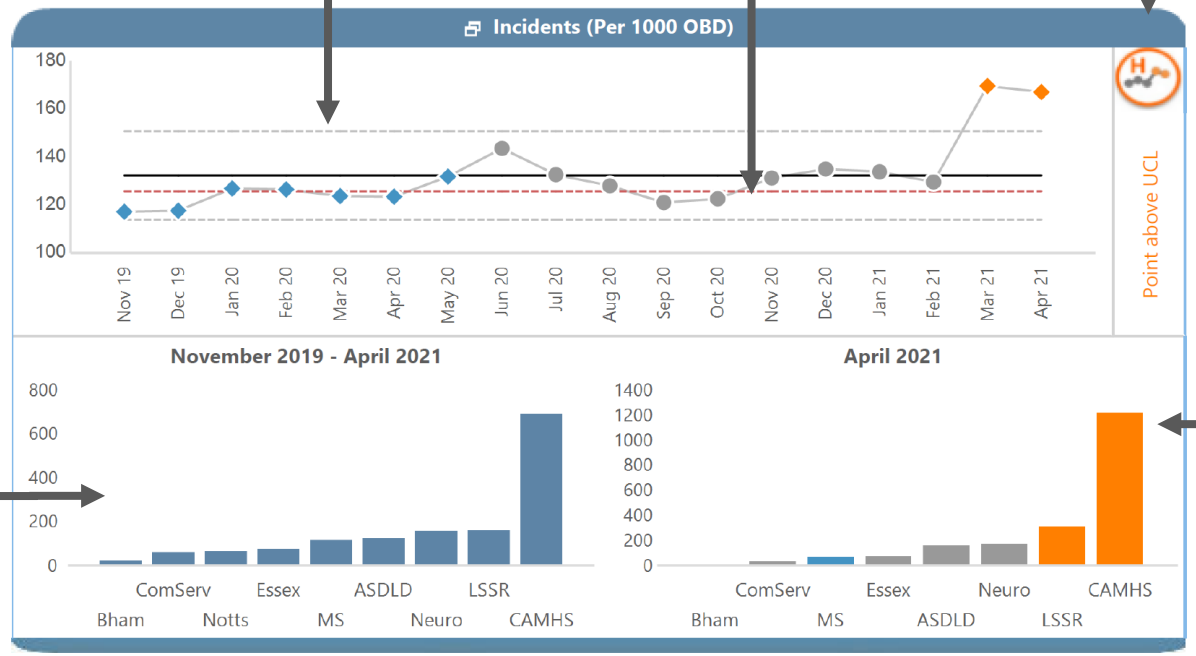
Proposed target for the KPI

SPC icon for the latest month

Orange icon = Special cause concern
Blue icon = Special cause improvement
Grey icon = Common cause variation
Trend line = Not enough data for statistical significance. Icon replaced by trend line.

Charity level SPC chart

Shows the trend for the last 18 months as a per 1000 occupied bed days rate



Division average for the last 18 months

Helps understand how the last 18 months compare to the latest month

Latest month by Division

Shows how Divisions are contributing to the overall charity level in the SPC chart above.

The bar colour illustrates if a Division itself has an SPC concern/improvement

Example Narrative

April 2021 shows an SPC special cause concern as the data point is above the Upper Control Limit.

The latest month Division chart shows that CAMHS and LSSR are high contributors, with both triggering an SPC special cause concern in their own data. Although their high contribution is in line with the last 18 months trend, the latest month rate is much higher.

Whilst the charity position is concerning, MS is showing special cause improvement for April 2021.

Paper for Board of Directors

Topic	Estates & Facilities Update
Date of meeting	Thursday, 25 November 2021
Agenda item	**11**
Author	Alex Trigg
Responsible Executive	Alex Trigg
Discussed at previous Board meeting	Updates on Estates & Facilities have been discussed at the Charity Executive Committee meetings
Patient and carer involvement	Where patients have been involved in topics within the paper this has been specifically highlighted in the relevant section.
Staff involvement	Where staff have been involved in topics included within the paper this will be highlighted specifically in the relevant section
Report purpose	Review and comment ☐ Information ☒ Decision or Approval ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☒ Buildings and Information ☒ Innovation and Research ☒
Committee meetings where this item has been considered	

Report summary and key points to note

The attached is the Director of Estates & Facilities update to the Board of Directors providing an overview of Estates & Facilities Activity covering Strategy, Soft Facilities Management, Hard Facilities Management and Project Delivery.

Appendices

Director of Estates & Facilities

Update Paper

This paper serves as the Director of Estates & Facilities update to the Board on estates and facilities activity to provide information and assurance on the key areas of focus both completed and in planning since the prior update in May 2020.

1. Strategy

   We have delivered the disposal of Spring Hill House, which completed on the 9th November 2021. The site was purchased by a local developer who will now seek planning consent for change of use to residential flats.

   An outline Estates Strategy is under preparation for submission to the Charity Executive Committee in December which will be segmented by three key areas:

   - Support for Partnerships and Promotion – an options appraisal setting out the means of delivering our platform for Community based care provision. This will support the January Board update on our Community proposals.
   - Future use of the Main Building – it is broadly considered that the main building's future use will support our strategic objective with respect to Research and Education. Initial executive discussions have been undertaken in order to form an illustrative brief, subsequently supported by Architects and Heritage consultants. We have submitted a 'pre-application' to Heritage England in order to gauge their initial view on the potential change of use, and change of building footprint.
   - Carrying out a strategic review of estate's assets and developing a group to drive this work that will be drawn from the executive, Board and Court of Governors.

2. Soft Facilities Management

   Following the completion of a trial for the provision of patient catering via 'Cook Freeze' proposals, the initiative was cancelled on the basis of patient feedback. Additionally, trials of purchased dysphagia were undertaken but rejected on the basis of quality. We are therefore continuing with 'Cook Fresh' across our five kitchens, and maintain our dysphagia kitchen in Smyth House.

   As a consequence of not proceeding with 'Cook Freeze', we are accelerating the implementation of a tablet based patient food ordering system 'Maple'. This enables patients to order their menu choices on a daily or weekly basis based on their preferences, and crucially also allows for cancellation of meals should the individual's plans change. The roll out is progressing well within the Northampton site with Fitzroy, Smyth and William Wake House utilising the system with the roll out continuing through December. It is due to be rolled out to Birmingham and Essex in January and February respectively. The system has been received well by patients.

   In July we commenced a restructuring of our Northampton based Housekeeping Teams. Previously, ward based teams had reported into ward managers and centrally based cleaners to estates and facilities. This was regularised with all cleaners now managed by the estates and facilities function. The positions of housekeeping team leader roles were confirmed, and certain functions such as cleaning audit personnel dedicated to functional

areas to improve consistency. Additionally, IPC training was refreshed for the housekeeping cohort, and training provided on the revised the National Standard of Healthcare Cleanliness which sets out defined targets. This work stream supports improvement in the Standard of Ward Cleanliness reported at ARC.

We are working as a part of the MHOST/Allocate Project delivery team to recruit servery assistants to deliver meal services for lunch and dinner. At present, ward based staff serve meals to patients which impacts staffing and also drives potentially inconsistent standards in terms of compliance.

I am pleased to report that the Charity wide Housekeeping teams were awarded St. Andrews Team of the Year at the Annual Awards. This was achieved as the result of a number of nominations highlighting the Team's outstanding contribution to the management of the pandemic.

3. Hard Facilities Management

The Head of Hard Facilities Management left the business in October. This is a key role and recruitment is currently underway for an individual to lead the maintenance and repair team. The role is currently being covered by the Deputy Director of Estates & Facilities whom we successfully recruited in the spring. We are also recruiting a Compliance and Governance Lead to build expertise in the key area of Statutory Compliance and support the embedding of improved Health and Safety practice within the function.

In preparation for the onset of winter we have reviewed our emergency procedures and preparedness in-conjunction with the ERPP team to manage and minimise any disruption should it occur.

4. Project Delivery

The Capacity Creation scheme is nearing closure. Estates & facilities have completed 28 ward moves across the period June 2020 to October 2021 and have readied two wards for occupation – Upper Harlestone and Mackaness. Two moves remain – Berkeley Close to Elgar and Allitsen. It is currently planned to complete these early in the new year following staff and patient feedback.

Estates & facilities are supporting the appropriate elements of the Quality Improvement Programme (QIP) associated with the recent Men's and Women's Medium Secure inspection particularly with respect to seclusion suites and specific observations associated with ward environments for ASD and LDA patient cohorts. This will afford an excellent opportunity for patient co-production. In addition and in anticipation of the forthcoming Neuro inspection, we are working with clinical teams to identify improvements to the environment and address operational issues

Tenders have been returned for alterations to Birmingham's Women's Medium Secure to provide an improvement to the extra care suite on Hazelwell as the first of two phases.

Alexander Trigg - Director of Estates & Facilities - 18th November 2021

Paper for Board of Directors	
Topic	CQC Inspection Reports – Men's and Women's Services
Date of Meeting	Thursday, 25 November 2021
Agenda Item	**12**
Author	Jenny Kirkland
Responsible Executive	Andy Brogan
Discussed at Previous Board Meeting	August 2021 September 2021
Patient and Carer Involvement	Nil these are reports written by an external agency.
Staff Involvement	Nil these are reports written by an external agency.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Quality ☒ People ☒ Delivering Value ☒ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Considered at Committee Meetings	Quality & Safety Committee Charity Executive Committee

Report Summary and Key Points to Note

Following an inspection in the summer the charity have received the CQC inspection reports for the Men's & Women's services. The services have been rated Requires Improvement and Inadequate respectively which is no change from the previous inspections.

The main issues identified in these reports include;

Staffing
Enhanced Support
Incident Management
Leadership
Training and
Quality of care

Whilst we received these finalised in November we had responded earlier to the initial feedback reports by developing a comprehensive quality improvement programme, delivered in partnership with members of the East Midlands Alliance and led by Northamptonshire NHS Foundation Trust.

The two reports are included as annexes at the end of the Board pack

Appendices/Annexes:

Annex 1 – St Andrew's Healthcare – Men's Service Inspection Report

Annex 2 – St Andrew's Healthcare – Women's Service Inspection Report

Paper for Board of Directors	
Topic	Education
Date of Meeting	Thursday, 25 November 2021
Agenda Item	**13**
Author	Cheryl Smith, Head Teacher, Holly Taylor, Director of Learning & Development, Dr Peter McAllister Associate Medical Director
Responsible Executive	Martin Kersey
Discussed at Previous Board Meeting	24 September 2020
Patient and Carer Involvement	Adult and CAMHS Patients receive Education services, Peer Support Workers work on Wards, REDS co-production of courses, Trainee Doctors and Students support patients
Staff Involvement	Staff engage with L&D, students engage with patients, Peer Support Workers with REDS
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☒ **C** ☒ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	n/a

Report Summary and Key Points to Note

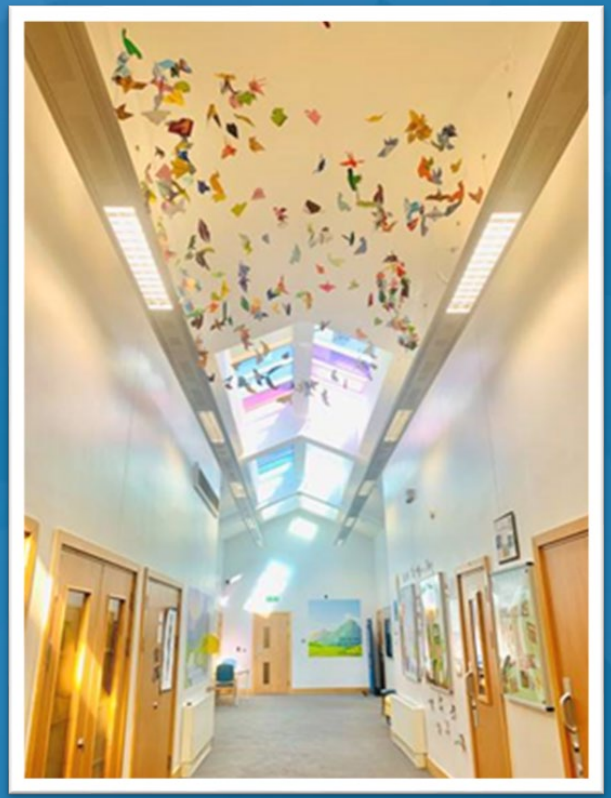
Education Overview for:

Adult and CAMHS Patients
Learning & Development, REDS
Medical Education

Appendices

Education

Cheryl Smith



St Andrew's School Mental Wellness Programme

Transforming lives together

What do we offer?

St Andrew's College – Our Ofsted registered independent school for young people in the CAMHS service providing individualised, trauma informed education programmes

Adult Education - Provision of education for adult patients across the charity wishing to develop their vocational, numeracy and literacy skills, and attain academic qualifications or learning. There is provision in Birmingham, Essex and Northampton.

Libraries – Access to library services for all of our patients across all of our St Andrew's sites.

LightBulb – A mental wellness programme for schools in the community to support schools with building a positive culture of, and awareness around mental health.

Key Achievements

Ofsted – The college was inspected in June 2021 and achieved an overall rating of ‘good’ with ‘outstanding’ for behaviour and attitudes.

Qualifications - Our college students achieved 177 separate qualifications this year including three grade 9 GCSE’s

Duke of Edinburgh Awards - One student has completed their bronze award in the college, and two more are very close to completion. A student in Adult Education is nearing completion of their silver award.

Lightbulb mental Wellness Programme - NHSE funded a pilot of our LightBulb programme in Northamptonshire secondary schools providing £30k for us to it deliver to 20 schools. It has been very successful.

What we are working on

Ofsted – we are focused on achieving ‘outstanding’ across all domains in our next inspection of the college.

Duke of Edinburgh – we are looking to increase the numbers of D of E achievements for our students and trial a peer mentoring programme in schools for the volunteering section of the D of E

Lightbulb rollout – we are looking to increase our range from local to regional, and then national

Scholarships / careers – working with secondary schools to incorporate mental health careers into their careers curriculum and offering scholarships places for aspiring nurses via our academic department.

Scoping - for further community reach ideas

St Andrew's HEALTHCARE

Find out more about our Lightbulb programme here…

St Andrew's HEALTHCARE

Learning & Development

Holly Taylor, Director of L&D

St Andrew's HEALTHCARE

Learning & Talent Development

1. **Ensure** everyone receives an **inspiring induction**
2. **Deliver** efficient & effective **mandatory training**
3. **Enhance clinical & specialist skills**
4. **Leverage** our **literacy** (digital and functional)
5. **Build leadership capability**
6. **Maximise** talent, **succession planning & grow careers**
7. **Celebrate a learning culture**

Transforming lives together

What do we invest in & Why?

Mandatory Training & Induction

Legal & Regulatory
Compliance & Assurance
Safety Culture & C.A.R.E
Values

The ASPIRE programme

Increasing our supply of Registered Nurses
Attraction & Retention of Talented People

The REDS Academy

Recovery College
Co-production of Learning
Accessible by All

Core & Specialist Clinical Skills

Quality of Care
Best Practice & Innovation
Parity of Esteem

Clinical Higher Education

Career Development
Professional CPD
Attraction & Retention

Digital e-learning & IT systems

Accessibility
Speed & Flex of Delivery
Efficiency & Lowering Costs

Management, Leadership, & IPDR

Increasing Management Capability
Performance Management
Talent Development

Apprenticeships

Career Development
Workforce Planning
Access to Work & Study

External Students

Recruitment Pipeline
Quality & Innovation
Community links

"Attracting, retaining & growing our people to deliver great care – today & tomorrow "

St Andrew's HEALTHCARE

Key Achievements

Career Development – **187** people have passed a long term Qualification relevant to their role in the last 12 months.

Leadership Development – Programmes are available at every level *(first line to Director),* alongside growing **30** internal qualified coaches and a pool of **40** mentors.

Digital Learning - New ways of learning enabled accessibility during the pandemic. Over **190** courses are available on our iAcademy with **65,000** e-learning modules completed.

Compliance & Induction - **92%** Compliance for mandatory Training and over **1,200** people inducted into the charity.

Clinical Skills - Supporting divisions with **service improvement plans**. From designing training plans to delivering ward based learning and coaching.

St Andrew's HEALTHCARE

What we are working on

CQC action plans – Supporting services with driving through and leading change.

Reducing time to hire & aiding retention – increasing number of induction programmes and mobilising local inductions.

Mandatory training – catching up plans on key topics such as ILS, Safeguarding and SIT training.

Local learning systems – supporting Career Cafes to support development planning, promote 1-2-1's, Team meetings, de-briefs, mentoring etc.

Co-production standard – Adopting the REDS kite mark across the L&D family of products and services.

Ofsted & Regulators – Laying the foundations for external growth.

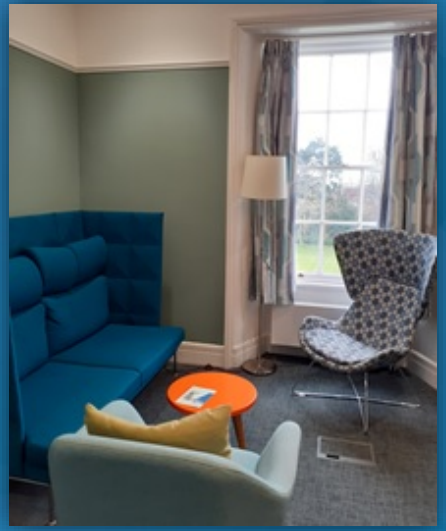
Workbridge – Review of services & change plan.

St Andrew's HEALTHCARE

Celebrating Success

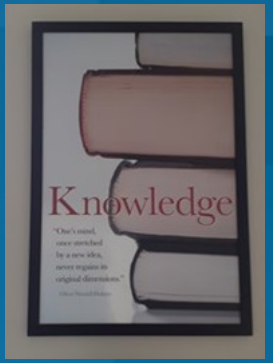
Medical Education

Dr Pete McAllister



St Andrew's HEALTHCARE

Academic Centre
Part of St Andrew's Healthcare



THE UNIVERSITY OF BUCKINGHAM MEDICAL SCHOOL

UNIVERSITY OF CAMBRIDGE

Transforming lives together

- **New secured funding for each Doctor**
- Building on the MTI success- 2 new additions, Nov & Jan
- **Starting a Balint Group**
- **Forging links with local deanery for post-graduate training slots**

Continue to get the best feedback from both Cambridge & Buckingham

Positives:

- Staff were very helpful on all wards
- CTFs were “excellent”
- They saw many examples of caring and compassionate interactions
- Impressed by MDT working
- Felt the ward hierarchies were flat and thought this was really good
- Examples of patient centred care
- Participation in clinical audits was really helpful

- Still Buckingham Medical preferred partner
- As the Medical grows, they need us to take on more students in each block
- Limited increase in resources, but 2/3 increase in income!
- Exploring expansion of the Physician Associates in Birmingham, along with placing Warwick students in St Andrew's Birmingham
- University of Buckingham approaching NHFT for Medical Placements

Paper for Board of Directors	
Topic	Trauma Presentation
Date of Meeting	Thursday, 25 November 2021
Agenda Item	**14**
Author	Dr Deborah Morris
Responsible Executive	Martin Kersey
Discussed at Previous Board Meeting	24 September 2020
Patient and Carer Involvement	Patients have been involved in trauma research
Staff Involvement	
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☒ **C** ☒ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☒ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☐ Innovation and Research ☐
Committee meetings where this item has been considered	n/a

Report Summary and Key Points to Note

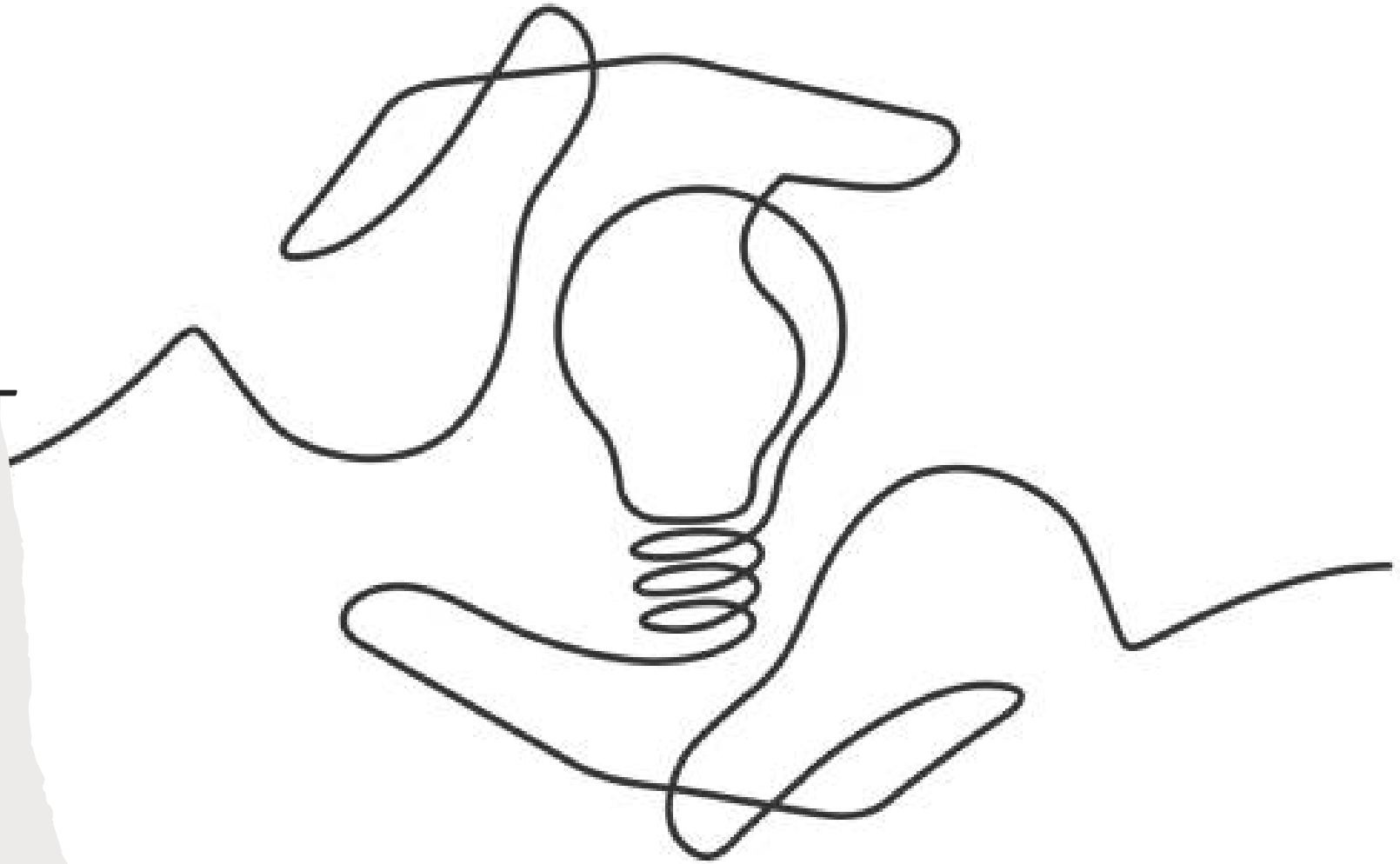
Centre for Developmental & Complex Trauma:

- Research
- Conferences
- CPD Activities

Appendices

The Centre for Developmental and Complex Trauma

Dr Deborah Morris



The Centre for Developmental and Complex Trauma: Who are we and what do we do

'To improve the representation and outcomes of marginalised populations who have experienced trauma'

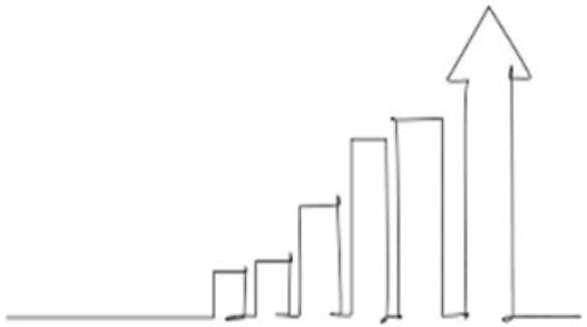
Established in the Charity in 2020

The 'core' team
1 x Consultant Clinical Psychologist
1 x Senior Research Assistant
1 x nurse (secondment)

The 'extended' team
5+ volunteer researchers
Placement students (2-6)
Trauma Advisory Group (4)
10+ clinicians involved at anyone time

Partnership and support from the Academic Centre

The Centre for Developmental and Complex Trauma: Who are we and what do we do



Research

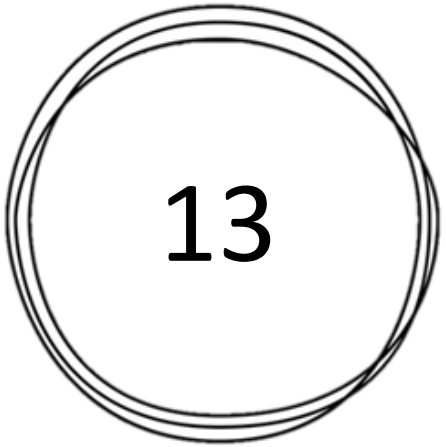
Conferencing

CPD activities

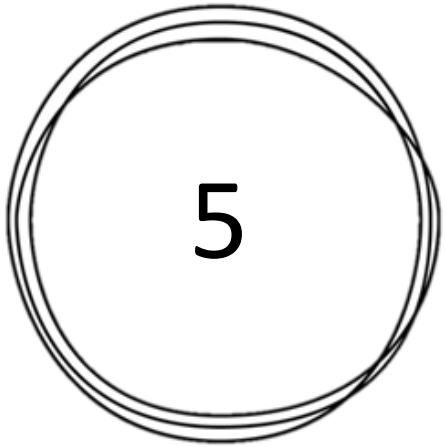
Our philosophy

'Go big or go home'

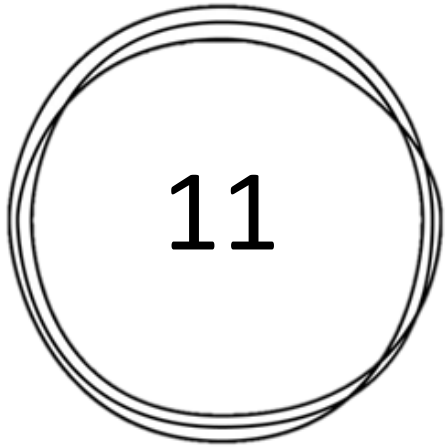
Key achievements so far: Research Outputs..



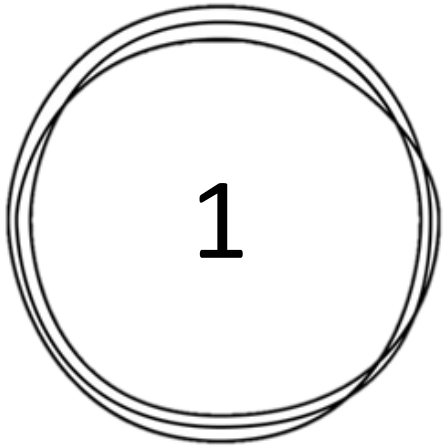
Peer reviewed journal publications



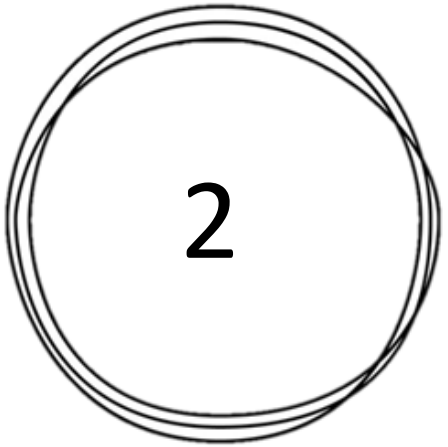
Conference papers



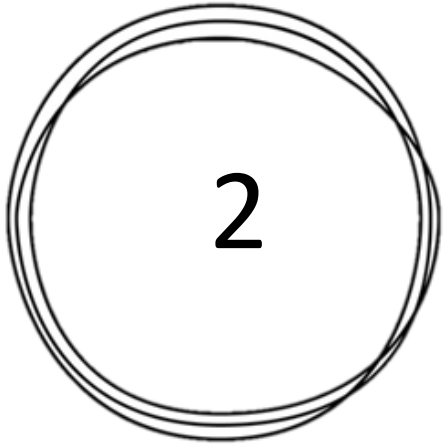
Conference posters



Book chapter

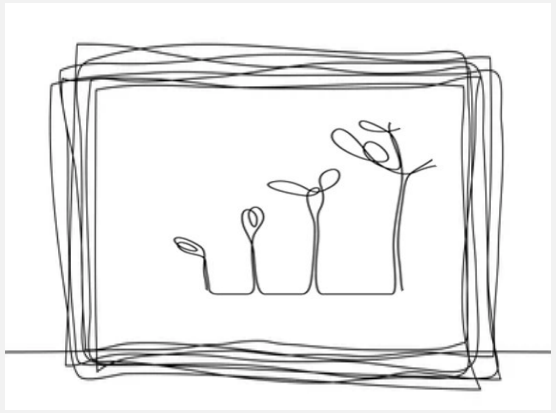


Journal papers / Book chapters In submission



Invited Guest Editor roles for Peer Reviewed Journals

Organizational impact?

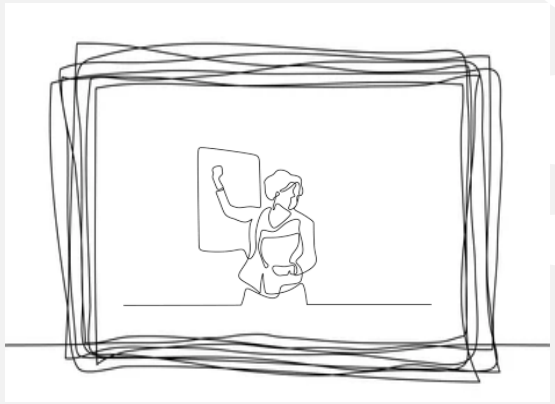


Nurturing talent and skills

20+ clinicians and students have worked with us.

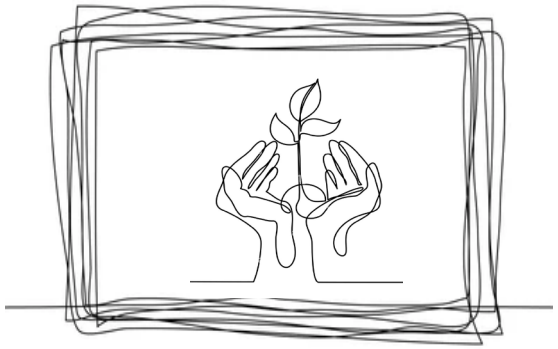
6 Assistant psychologists volunteer with us

20+ clinicians and students have published in peer review journal with us



New assessment pathways for clinical need

New trauma assessment processes initiated in DBT service and MSU as a part of our projects



Increasing ‘people’ Resources for wards

6 Student placements in our clinical services (People resources)

1 x Volunteer now working FT in STAH

Research outcomes.... Establishing a programme of investigation

- Applied Research programme that focuses on increasing understanding of patient and staff needs and improving practice

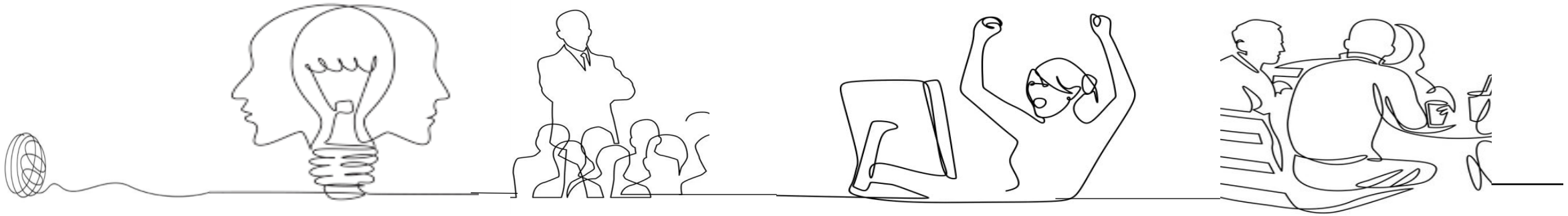
- There are four strands to the programme
  - Developmental trauma*
  - Complex PTSD*
  - Staff wellbeing*
  - Moral injury*

Wider outcomes: Reputational work.. Building partnerships and relationships

Conferencing and CPD programme

- Current conference programme
  - 4 x trauma focused conferences a year
- Key partnerships and additional conference outcomes
  - Strong national and international speaker profiles
  - International top 10 ranked experts (Globally) in trauma are presenting with us
  - Post conference: further collaborations in research, further presentations with STAH and the Trauma Centre being invited to present at International conferences.
  - Invitations to speak at NHS commissioning and RCP led teaching forum with senior RCP and commissioning figures

What has helped us grow.. and to keep growing?



‘bright ideas at the right time and a very motivated team

The right amount of support (and belief) from senior leadership in the Charity

Key people in and outside of the Charity that have 'opened doors'

Early (publishing) successes and invitations for collaborations

Clear KPI's

Strong partnerships

Next steps? – what are we working on: The 5 year plan

Research Programme

Conferences & Workshops

Post Graduate Education: MSc programme

The Journal of Developmental and Complex Trauma

Questions and thank you…..

Divisional Presentation (including patient voice) Locked & Specialist Rehab (LSSR)

Dr Sanjith Kamath, Deputy CEO
Dr Elizabeth Beber & Patient

(Presentation on the day)

Questions from the Public for the Board

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public

27th January 2022 9.00am

(Paul Burstow - Verbal)

Annexes

Annex 1
Men’s Inspection Report

Annex 2
Women’s Inspection Report

St Andrew's Healthcare

St Andrew's Healthcare - Mens Service

Inspection report

Billing Road
Northampton
NN1 5DG
Tel: 01604616000
www.stah.org

Date of inspection visit: 5-8, 20-21, 29 July 2021 and 3-5 August 2021
Date of publication: N/A (DRAFT)

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?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

Following our inspection we took urgent action because of immediate concerns we had about the safety of patients on the learning disability and autism wards. Conditions were placed on the provider's registration that included the following requirements; that the provider must not admit any new patients without permission from the CQC; that wards must be staffed with the required numbers of suitably skilled staff to meet patients' needs; that staff undertaking patient observations must do so in line with the provider's policy; that staff must receive required training for their role and that audits of incident reporting are completed. The provider is required to provide CQC with an update relating to these issues on a fortnightly basis.

Whilst the CQC acknowledge the impact of the COVID-19 pandemic on staffing across the health and social care sector, we had identified staffing issues at this location at our previous inspection. Our assessment process for rating services requires previous breaches to be considered.

- Senior managers and staff on the learning disability and autism wards did not always treat patients with compassion and kindness and did not always support, inform and involve families or carers. Staff at the learning disability and autism wards were unable to define a closed culture or describe how they ensured patients were protected from the risks associated with a closed culture developing. Staff on the learning disability wards and forensic wards did not always treat patients in seclusion with dignity and respect.
- The psychiatric intensive care ward, forensic wards and learning disability and autism wards did not always have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients regularly had their escorted leave, therapies or activities cancelled or cut short because of staff shortages.
- Staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. This happened on the psychiatric intensive care ward, forensic wards and learning disability and autism wards. Staff did not always know what incidents to report and how to report them at the forensic wards, long stay rehabilitation wards and learning disability and autism wards. Staff were not always updating patient risk assessments and care plans at the forensic wards, long stay rehabilitation wards and learning disability and autism wards. Staff did not always ensure patients' physical healthcare needs were met at the forensic wards and learning disability and autism wards. Staff were not always following systems and processes when administering, recording and storing medicines on the learning disability and autism wards. Not all ward areas at the long stay rehabilitation service and learning disability and autism service were safe, clean and well maintained.
- Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice on the forensic wards, long stay rehabilitation wards and learning disability and autism wards. When a patient was placed in seclusion, staff did not always follow best practice guidelines on the forensic wards and learning disability and autism wards. When a patient was placed in long term segregation, staff on the forensic wards and learning disability and autism wards did not always follow best practice guidelines in the Mental Health Act Code of Practice.
- Managers did not ensure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care on the forensic wards and learning disability and autism wards. Staff did not always provide a range of care and treatment suitable for the patients in the long stay rehabilitation wards and learning disability and autism wards. The service had not fully responded to the needs of patients with autism at the learning disability and autism service.

Summary of findings

- Leadership and governance arrangements across all core services had not addressed previous issues or ensured concerns were identified and acted on. The provider's data was not always accurate. Not all leaders had a good understanding of the services they managed. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.

However:

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another service. As a result, discharge was rarely delayed for other than clinical reasons.
- The provider had a care awards initiative to celebrate success and improve the quality of care across services. Staff engaged in local and national quality improvement activities. The provider reported involvement in various research projects.

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 	Our rating of this service stayed the same. We rated it as requires improvement because: • Staff had not recognised or reported one safeguarding incident and we were not assured staff knew when to escalate incidents such as financial issues. • Only 54% of registered nurses completed immediate life support training. This posed a risk to patients who require immediate medical attention. Across the service five out twelve nurse call alarms were either not working or damaged. • Staff were not always completing patient's observation records accurately. CQC reported on this at our earlier inspection. Staff did not always receive breaks between observing patients. • Five of eighteen care plans we reviewed were incomplete and staff had not followed up on the progress notes. Staff had not followed physical healthcare plans of two patients. We found similar issues at our inspection in March 2018. None of the care plans had clearly recorded consent to treatment. • Seclusion rooms on all wards met most but not all guidance in the Mental Health Act Code of Practice. There was no exit plan for a patient in long term segregation on one of the wards. Staff did not always keep clear records or follow best practice guidelines when patients were in long term segregation or seclusion. We reported on similar issues at our inspection in March 2018. • Staff did not always protect the privacy and dignity of a patient in prolonged seclusion. • Processes for recording staff supervision were not robust. We reported on similar issues at our earlier inspection.

Summary of findings

- The service did not have enough nursing or support staff to keep patients safe and ensure all patients care needs were met all the time. CQC reported on this at our inspection in March 2018.
- Senior leaders were not always visible on the wards. Two managers told us they did not feel supported by senior leaders on matters such as staffing levels and recording supervision. These managers told us they felt senior managers did not fully appreciate the pressures faced by staff on the wards and their focus was on different priorities for the service.
- Governance systems and processes were not always robust. We were not assured managers would recognise and identify all potential risk issues.

However:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose. Cleaning records were complete and up to date.
- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.
- Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Summary of findings

We rated this service as requires improvement because it was not safe, effective, caring or well led.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Our rating of this location went down. We rated it as requires improvement because:

- Staff had not completed discharge plans for all patients. Patients were not always aware of their specific goals for discharge.
- Clinic rooms were not adequately equipped to meet patient need. Two of the three wards did not have access to emergency resuscitation equipment on the ward. All three wards did not have oxygen signs on the clinic room door.
- Staff had not labelled all opened food items in the fridge, which was identified as an action from the last inspection in March 2018.
- Staff did not always report safety or safeguarding incidents. These incidents had not been reviewed effectively and patient care needs had not been updated.
- The providers compliance with safeguarding level three training on two of the three wards was low at 60% and 63%.
- Managers allocated therapy staff to frontline shift work due to staffing shortages which impacted on the delivery of therapies to patients.
- Patients leave was affected by and planned around staffing levels and not around patient choice. We found therapy sessions had been cut short or cancelled due to staffing levels.
- The seclusion rooms consisted of blind spots that the staff were not aware of increasing the risk of patients harming themselves without staff knowing when using the facilities. We found blind spots in the garden that the staff were not aware of.
- Staff did not always learn lessons from incidents and follow processes put into place after incidents.

However:

- Staff monitored and supported patients' physical health.
- 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.

- All ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

We rated this service as requires improvement because it was not safe, effective or well led.

Wards for people with learning disabilities or autism

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- Senior managers and staff did not always treat patients with compassion and kindness. Staff did not always support, inform and involve families or carers. Staff were unable to define a closed culture. Staff kept a patient in seclusion for longer than required.
- The service did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients regularly had their escorted leave, therapies or activities cancelled or cut short because of staff shortages.
- Staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff did not always know what incidents to report and how to report them. Staff were not always updating patient risk assessments and care plans. Staff did not always ensure patients' physical healthcare needs were met. Staff were not

Summary of findings

always following systems and processes when administering, recording and storing medicines. Not all ward areas were safe, clean and well maintained.

- Seclusion rooms did not meet all of the guidance in the Mental Health Act Code of Practice. When a patient was placed in seclusion, staff did not always follow best practice guidelines. When a patient was placed in long term segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice.
- Managers did not ensure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff did not always provide a range of care and treatment suitable for the patients in the service.
- The service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Senior managers and staff were sometimes dismissive of complaints from patients with autism. Not all patients could make hot drinks and snacks at any time.
- Leadership and governance arrangements had not addressed previous issues or ensured concerns were identified and acted on. The provider's data was not always accurate. Leaders did not always have a good understanding of the services they managed. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.

However:

- The provider evidenced sharing of national safety alerts and action taken to ensure wards acted as required.
- Staff completed comprehensive mental health and physical health assessments of each patient either on admission or soon after.

Summary of findings

- Staff received and kept up-to-date with training on the Mental Health Act and Mental Capacity Act.
- We observed staff treating patients with respect, kindness and dignity and responding to their needs during the site visit.
- Staff engaged in local and national quality improvement activities. The provider reported involvement in various research projects

We rated this service as inadequate because it was not safe, effective, caring, responsive or well led.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- The ward was regularly short staffed because managers moved staff to other wards to cover shortfalls.
- Staff undertook patient observations for long periods of time without a break. This impacted on staff well-being, morale and patient care. Observations were not completed in line with policy and guidelines by the National Institute for Health and Care Excellence.
- We were not assured staff knew the individual risks for patients which meant they might not be able to identify a deterioration in patients mental health, which may put staff and patients at risk.
- The manager did not share lessons learned with the whole team when things went wrong. Improvements were not always identified or shared within the team.
- The leadership, governance and culture for the ward did not always support the delivery of high-quality person-centred care. Staff did not always raise concerns as they felt they were not always taken seriously, appropriately supported, or treated with respect when they did.
- Not all leaders had the necessary experience, knowledge, capacity, capability or integrity to lead effectively.
- Staff did not understand how their role contributed to achieving the service strategy.

Summary of findings

- Staff did not always feel respected, supported or valued.

However:

- The ward environments were clean. Staff minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by comprehensive patient assessments. The ward 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. Patients' comments were overwhelmingly positive. A patient told us the staff aided their management of anxiety and reduced incidents.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The provider had a care awards initiative to celebrate success and improve the quality of care across services.

We rated this service as requires improvement because it was not safe or well led.

Summary of findings

Contents

Summary of this inspection

Background to St Andrew's Healthcare - Mens Service

St Andrew's Healthcare Men's location has been registered with the CQC since 11 April 2011. The service has a registered manager and a controlled drugs accountable officer.

This location consists of four core services: acute wards for adults of working age and psychiatric intensive care units; long stay/rehabilitation mental health wards for working age adults; forensic/inpatient secure wards; wards for people with learning disabilities or autism.

St Andrew's Healthcare Men's location is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

This location has been inspected ten times. The most recent inspection in July 2019 was a focused inspection of one ward, which subsequently closed.

The last comprehensive inspection of this location was in March 2018. The location was rated as requires improvement overall; requires improvement for safe, good for effective, good for caring, requires improvement for responsive and requires improvement for well led. We issued requirement notices for breaches of the following regulations:

- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 210 Safe care and treatment.
- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 210 Good governance.

We found that the provider addressed some, but not all of the issues from the last inspection. The issues that remain are identified later in this report.

The following services and wards were visited on this inspection:

Acute wards for adults of working age and psychiatric intensive care units:

- Heygate ward, a psychiatric intensive care unit with 10 beds.

Forensic inpatient/secure wards:

- Robinson ward, a medium secure ward with 17 beds.
- Fairbairn ward is a 15 bed ward in purpose-built medium secure service which manages Deaf or hearing impaired (profound, severe, partial or hard of hearing) patients' with complex mental illness in a culturally sensitive environment.
- Prichard ward, a medium secure ward with 15 beds.
- Rose ward, Rose ward, a medium secure ward with 17 beds for people with an acquired brain injury.
- Cranford ward, a medium secure ward with 17 beds for older males.

Long stay / rehabilitation wards for working age adults:

- Berkeley Lodge which provides support for up to six male patients in a locked rehabilitation environment.

Summary of this inspection

- Spencer North (previously Church ward) ward which provides support for up to 10 male patients in a low secure environment.
- Spencer South (previously Fenwick ward) ward which provides support for up to 13 male patients in a low secure environment.

Wards for people with learning disabilities or autism:

- Marsh ward (previously Mackaness ward), a 10 bed medium secure service for men with autistic spectrum conditions.
- Meadow ward (previously Mackaness ward), a 10 bed medium secure service for men with autistic spectrum conditions.
- Fern ward (previously Upper and Lower Harlestone wards), a 10 bed low secure service for men with autistic spectrum conditions.
- Acorn ward, a 10 bed low secure service for men with autistic spectrum conditions.
- Sunley ward (previously Naseby ward), a 15 bed low secure service for men with autistic spectrum conditions.
- Hawkins ward, a 15 bed medium secure service for men with learning disabilities.

What people who use the service say

We spoke with 43 patients.

At the psychiatric intensive care unit, we spoke with three patients. Patients' comments were overwhelmingly positive. A patient told us the staff aided their management of anxiety and reduced incidents.

At the forensic service we spoke with 17 patients. Patients had mixed views about the service. While 14 patients agreed the facilities available to them at St Andrews were excellent, ten patients said the food was not good and seven patients commented that mealtimes were rushed as staff tried to rush them to eat so they could clear away and get back to the ward. All patients we spoke with commented on the shortage of staff and gave examples of how this impacted on them including; having to wait to be escorted off the ward for non-planned activities; having ward activities cancelled or changed due to lack of staff or staff being sent to other wards. Two patients said they did not like having to use e-cigarettes on Prichard ward rather than their own vapes; and two other patients said they did not like having only three snacks a day particularly when they felt they had not had time to finish their meals.

At the long stay / rehabilitation wards for working age adults we spoke with three patients. All patients told us staffing levels affected their section 17 leave and staff planned it to fit around staffing levels. Patients liked the food and reported good relationships with staff.

At the wards for people with learning disability or autism we spoke with 20 patients. Nine patients shared positive feedback about staff, describing them as caring and hard working. Five patients told us they did not feel safe (four of these were Hawkins ward patients). Five patients told us staff were disrespectful and sometimes rude. Three patients on Hawkins ward told us staff did not stop bullying from other patients. Two patients on a low secure ward told us they felt like they were in prison. Two patients told us they were not treated well. Two patients told us that night staff speak in their own language and two patients told us that night staff have been asleep, including when on patient observations.

We spoke with 14 carers.

At the psychiatric intensive care unit, we spoke with two carers who gave positive feedback about the staff. They said they felt well informed and could always talk to a staff member on the telephone.

Summary of this inspection

At the forensic service we spoke with four carers. All carers were positive about the service. They felt staff were efficient and understanding and staff they had spoken with seemed to know their relative well. They all said they received information about care reviews. One carer said her relative felt very safe at the hospital and three carers felt their relatives had continued to make good progress in the last year despite COVID-19 restrictions. Three of the four carers said their relatives had benefitted from very good physical healthcare at St Andrews.

At the long stay / rehabilitation wards for working age adults we spoke with two carers. One carer told us staffing levels affected patients Section 17 leave.

At the wards for people with learning disability or autism we spoke with six carers. Four carers (Acorn ward) expressed that communication from the service was poor describing it as “awful” and “non-existent”. One carer told us that staff were “indifferent”. One carer expressed frustration at trying to work with the service to support their relative and said they had “lost faith in them” (the service). One carer told us staff do not inform them about incidents despite an Irish High Court order stipulating the family must be kept informed. One carer said they strongly dispute the provider’s claim on their website that they work alongside families and told us they are not involved in care planning even though their son has consented to this. However, the other two carers reported positive experiences of their loved one’s care on Brook and Acorn wards.

How we carried out this inspection

The inspection team visited services and wards between 6 July and 8 July 2021 on 20 and 21 July 2021 and completed further off-site inspection activity until 5 August 2021. During the inspection we:

- Visited the service and observed how staff cared for patients
- Toured the clinical environments
- Looked at the medicine management on the wards
- Spoke with 43 patients that were using the service
- Interviewed 98 staff and managers, including ward managers, clinical leads, doctors, nurses, healthcare assistants, psychologists, occupational therapists, technical instructors and social workers
- Interviewed eight senior managers and the provider’s quality improvement lead
- Spoke with 14 carers
- Observed two community meetings, one staff debrief and two handovers
- Observed six episodes of care activities
- Reviewed 62 patient care records
- Reviewed policies and procedures relevant to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

Acute wards for adults of working age and psychiatric intensive care units core service:

- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure lessons learned are shared with the whole team when things go wrong. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure leadership, governance and culture supports the delivery of high-quality person-centred care. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure improvements are identified and shared within the team. (Regulation 17(1) (2) (a))
- The provider must ensure staff are informed and understand how their role contributes to achieving the strategy. (Regulation 17(1) (2) (a))

Forensic inpatient/secure wards core service:

- The provider must ensure that staff protect patient's privacy and dignity when patients are in seclusion. (Regulation 10 (1))
- The provider must ensure that all nurse call alarms are working and not damaged. (Regulation 12 (1) (2) (e))
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that all registered nurses have completed immediate life support training. (Regulation 12 (1) (2) (c))
- The provider must ensure seclusion room environments meet the Mental Health Act Code of Practice. (Regulation 12 (1) (2) (d))
- The provider must ensure patients are not secluded for longer than required. (Regulation 13 (1) (4) (b) (c) (d)
- The provider must ensure that all staff can recognise and report safeguarding incidents. (Regulation 13 (1))
- The provider must ensure that staff complete all care plans and progress notes fully, correctly and in a timely manner. That staff clearly record patients consent to treatment in the care plan and record the details of best interest meetings and decisions when applicable. (Regulation 17 (1) (2) (c))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Long stay / rehabilitation wards for working age adults core service:

- The provider must ensure effective discharge plans are in place for all patients. (Regulation 9 (3(b))
- The provider must ensure emergency resuscitation equipment is available on every ward. (Regulation 12 (1) (2) (e))
- The provider must ensure sharps logs are completed accurately on all wards. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure seclusion rooms do not contain blind spots and sharp edges on the viewing panes are mitigated. (Regulation 12 (2) (d))
- The provider must ensure there are oxygen signs on the clinic room door. (Regulation 12 2 (d))
- The provider must ensure all blind spots in the Spencer North and Spencer South communal areas are mitigated. (Regulation 12 2 (d))
- The provider must ensure clinic rooms are suitable and suitably equipped to meet patient needs on all wards. (Regulation 12 (2) (e))
- The provider must ensure all staff have undertaken safeguarding level three training where it is a requirement for their role. (Regulation 13 (1) (2) (3))
- The provider must ensure staff report and record all incidents appropriately, notifying external agencies when required. (Regulation 12 (1) (2) (a) (b))

- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Wards for people with learning disabilities or autism core service:

- The provider must ensure the service provides a range of care and treatment suitable for the patients in the service. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure that staff support, inform and involve all families or carers in line with patient wishes. (Regulation 9 (1) (3) (f))
- The provider must ensure the wards respond to the needs of patients with autism in the ward environment. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure staff treat patients with kindness, respect and dignity at all times, including use of appropriate language. (Regulation 10 (1))
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure staff report and record all incidents appropriately, notifying external agencies when required. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d))
- The provider must ensure staff complete individual risk assessments and care plans for all patients. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure the proper and safe management of medicines. (Regulation 12 (1) (2) (g)
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and section 17 leave. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure seclusion room environments meet the Mental Health Act Code of Practice. (Regulation 12 (1) (2) (d))
- The provider must ensure staff complete and update their mandatory training. (Regulation 12 (1) (2) (c))
- The provider must ensure staff meet patient's physical healthcare needs. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure patients are not secluded for longer than required. (Regulation 13 (1) (4) (b) (c) (d)
- The provider must ensure all staff are aware of what constitutes a closed culture. (Regulation 13 (1) (2))
- The provider must ensure they respond to all patient complaints in line with policy and procedure. (Regulation 16 (1))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))
- The provider must ensure that staff receive the required specialist training to carry out their roles effectively. (Regulation 18 (2) (a))

Action the service SHOULD take to improve:

Acute wards for adults of working age and psychiatric intensive care units core service:

- The senior leadership team should continue to improve connections with frontline staff (Regulation 17 (1) (2) (e) (f))

Forensic inpatient/secure wards core service:

- The provider should ensure that all staff follow infection prevention and control procedures. (Regulation 12 (1) (2) (h))
- The provider should ensure that staff include all potential ligature risks on their ligature assessments and audits. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure that staff are aware of and follow the mitigation for all blind spots. (Regulation 12 (1) (2) (a) (b))

Summary of this inspection

- The provider should ensure that there is adequate medical cover on all wards. (Regulation 18 (1))
- The provider should ensure staff have access to regular team meetings and reflective practice sessions. (Regulation 18 (2) (a))
- The provider should ensure that senior managers are visible on the wards and make themselves accessible to staff and patients. (Regulation 17 (1) (2) (e) (f))
- The provider should ensure that the recording of staff supervision is robust. (Regulation 17 (1) (2) (d))

Long stay / rehabilitation wards for working age adults core service:

- The provider should mitigate all ligature risks in communal areas even if the area is not in use. (Regulation 12 (1) (2) (a) (b) (d))
- The provider should ensure auditing systems are in place to ensure all incidents are reported and actioned appropriately. (Regulation 17 (1) (2) (f))
- The provider should ensure issues raised by patients and staff are addressed in set timescales. (Regulation 17 (2 (e))
- The senior leadership team should continue to improve connections with frontline staff (Regulation 17 (1) (2) (e) (f))

Wards for people with learning disabilities or autism core service:

- The provider should ensure they meet the cultural and spiritual needs of all patients. (Regulation 9 (1) (b) (c))
- The provider should ensure that robust and effective handovers take place to ensure that information about risk and patients' care is communicated to support patient safety. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure that the service reviews the use of blanket restrictions. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure they provide outcomes to issues raised in governance meetings. (Regulation 17 (1) (2) (e) (f))
- The provider should ensure that staff feel able to raise any concerns without fear of retribution from senior managers. (Regulation 17 (1) (2) (e)
- The senior leadership team should continue to improve connections with frontline staff (Regulation 17 (1) (2) (e) (f))
- The provider should ensure staff have access to regular team meetings. (Regulation 18 (2) (a))
- The provider should ensure staff receive regular supervision. (Regulation 18 (2) (a))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Wards for people with learning disabilities or autism	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and updated risk assessments of all ward areas to highlight ligature points, however, staff had not identified exposed leads for the games console on Fairbairn ward as a potential ligature risk. The mitigation for ligature points, as stated on the risk assessment, was that all patients had individual ligature risk assessments. We looked at three patient care records on this ward and none of them had individual ligature risk assessments. A manager confirmed they did not complete these risk assessments for patients.

While staff could observe patients in all parts of the wards, we found blind spots in the courtyards on Cranford and Robinson wards that staff had not included on the environmental risk assessments. The mitigation for blind spots on the wards was that for areas which staff could not monitor by mirrors or closed circuit television cameras, staff would supervise patients in the area. We saw that staff left the doors to the courtyards open so patients could easily access areas where there were blind spots in the outside area, and there were no staff in the area to observe patients going out.

The ward complied with mixed sex guidance; all wards were male only.

Five out of twelve staff call alarms were either not working or damaged. During the inspection the team was issued with 12 call alarms. We found two that did not work which ward staff exchanged for us, and a further three had broken and staff repaired with tape.

All patients had easy access to nurse call systems that were working, either personal alarms where staff completed a risk assessment or alarm buttons in patient areas and bedrooms.

Maintenance, cleanliness and infection control

Except for some minor damage in the seclusion rooms, all ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up to date.

Most staff followed infection control precautions and sanitisers and face masks were readily available on all the wards. However, on Cranford ward not all staff were using the handwashing station or sanitiser every time they left or came onto the ward. On Cranford ward and Rose wards staff were not wiping down all shared equipment and tables in the nursing office. This meant that staff were not following all COVID-19 cleaning guidance.

Seclusion rooms

Seclusion rooms on all wards met some, but not all the guidance in the Mental Health Act Code of Practice.

Cranford ward seclusion room had two screws in the light fitting that needed securing. On Fairbairn ward the seclusion room was in long term occupation. We saw that the mattress was damaged.

On Prichard ward there was staining on the window surround and on Robinson ward there were stains around the closed circuit television camera. A second seclusion room on Robinson ward was not in use and converted into a de-escalation room. On Rose ward the viewing panel in the door was obscured by scratches this meant that line of sight was obscured. On Prichard and Rose ward seclusion rooms staff were unable to open the window blinds.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing or support staff. However, staff received basic training to keep people safe from avoidable harm.

Nursing staff

Staff, managers and patients we spoke with told us there were not enough staff on the wards to meet their needs. However, data submitted by the provider showed this service was over establishment during the period 1 April 2021 to 30 June 2021. However, managers told us the over establishment was due to staff recruited to the new Mackaness ward, due to open at the end of June 2021 currently working on Prichard ward as part of their induction process.

We spoke with 27 staff members, seven managers and 17 patients. All staff, four managers and eight patients told us there were not enough staff to meet all their needs. One staff member on Rose ward and a manager explained that safe staffing numbers were inaccurate because two staff members were currently nursing a Rose ward patient on another ward, thereby reducing the safe staffing numbers available on Rose ward by two staff, before any other absences.

On Rose ward on 7 July 2021 we noted that safe staffing levels were 11 and optimal staffing levels were 12. On this day the shift started with six staff and by 9.30 they had nine staff (this included an occupational therapy assistant acting as healthcare support workers). By lunchtime another staff member from Prichard ward appeared and the ward worked with ten staff for the remainder of the shift. The ward needed to use members of the multidisciplinary team in support

worker roles to ensure the ward met safe staffing levels. The clinical nurse lead, who was managing the ward that day in the absence of the ward manager, took on nursing duties as well as the management role. On the 8 July 2021 the ward was again short staffed by 2 people. On this occasion the inspector had to wait 15 minutes before a staff member was available to let them off the ward.

Staff and patients gave multiple examples of how staffing shortages impacted patient care. This included; disruption to patients routines, delays in responding to patient safety incidents, issues with the quality of patient records as time to write detailed notes and upload relevant documentation was not available to staff, staff ability to undertake safety checks and managers difficulties in providing effective and meaningful team meetings.

Registered nurse vacancy rates were 33% on Robinson ward; Rose 20%; Fairbairn 20% Cranford 12%, while Prichard was 7% over establishment, due to Mackaness staff temporarily working on this ward. Healthcare support worker vacancy rates were 9% on Robinson ward. While Prichard wards was 23% over establishment, Rose was 4% over establishment; Fairbairn 2% and Cranford 18% over establishment. This was due to Mackaness staff temporarily working on these wards.

Data relating to use of qualified agency staff across the directorate between 1 April 2021 and 30 June 2021, was 2%. While the use of bank staff including qualified and unqualified staff across the division was 19%.

The number of shifts filled by qualified agency staff was 2%; and unqualified agency staff was 3%. The number of shifts filled by bank qualified nurses was 9% and unqualified bank staff 22%. Less than 0.02 % of shifts were unfilled.

Staff turnover for the period 1 April 2021 to 30 June 2021 was 7% across all wards. Staff sickness for the period 1 April 2021 to 30 June 2021 was 8%.

Medical staff

Wards had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. However, one manager told us that getting locum doctor cover was sometimes difficult for the specialist wards. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Overall mandatory training compliance for the service in June 2021 was 90% for ward staff. However, immediate life support (ILS) for registered nurses was low at 54%. This posed a risk to patients as immediate life support may be required to save a patient's life in emergency situations.

Assessing and managing risk to patients and staff

Staff did not always manage all risks to patients or themselves. However, staff did use best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Requires Improvement

Forensic inpatient or secure wards

We reviewed 17 patient care records. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff also completed a COVID-19 screening risk assessment on admission.

Management of patient risk

Most staff knew about the risks to patients and usually acted to prevent or reduce risks. Most staff could identify and respond to changes in risks to, or posed by, patients. Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Staff had not completed patients observations correctly. We sampled ten patient's observation records across the service covering three weeks prior to inspection. On Fairbairn ward for the week commencing 01 July 2021 there were two gaps in the observation records for one patient. On Robinson ward for week commencing 20 June 2021 there was one gap in the observation record for one patient. We reported on this issue at inspection in July 2019. On Robinson, Cranford and Fairbairn wards we saw that staff had been observing patients for continuous periods of up nine hours without a break. This does not meet the requirements of the National Institute for Health and Care Excellence guidance which states that staff should break between patient observations every 60 minutes to two hours. This meant that staff could become fatigued with loss of concentration and may not be aware if a patient was in danger or not.

Use of restrictive interventions

Levels of restrictive interventions remained stable.

Between 01 April 2021 to 30 June 2021 there was one use of rapid tranquilisation on a patient across all wards, on Cranford ward. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

From June 2020 to June 2021 the number of seclusions by ward was; Prichard 27; Robinson 20; Rose 42; Fairbairn 18 and Cranford nine. Between 1 April 2021 and 30 June 2021 there were three episodes of long term segregation across all wards.

Staff did not always keep clear records or follow best practice guidelines when patients were in long term segregation or seclusion.

We reviewed seclusion paperwork of a Rose ward patient who was secluded on Fairbairn ward three times. The paperwork met some, but not all the guidance in the Mental Health Act Code of Practice. In one episode of seclusion, two medical reviews of the patient's seclusion were missing from the records. It was unclear from the patient's records when the seclusion ended. In the second episode of seclusion, the duty doctor decided to reduce the frequency of the medical reviews to twice daily, however, there was no recorded rationale for this. There were no recorded continuing medical reviews every four hours until the first multidisciplinary team review. The third record was contradictory. While a nursing review stated that the patient was awaiting transfer to an extra care facility when one became available. A ward round entry indicated that the patient had been, "relatively stable for the past two weeks whilst in seclusion" and would only move into long term segregation once there was enough staffing and an extra care suite available. For each episode of patient's seclusion, there was no evidence of an independent multidisciplinary team review after eight consecutive hours of the patient's seclusion. The patient's care plans gave no information about their privacy within the seclusion room en suite. We also noted that staff did not always fully complete food and fluid charts.

Long term segregation paperwork for a Rose ward patient did not identify the roles of staff involved in the decision-making process. There was a lack of therapeutic intervention to end the patient's long term segregation. Staff did not follow the patients care plan as the care plan stated the patient should have the support of two staff unless the patient requested, they leave, or the patient became threatening or hostile. However, on three separate occasions we saw that two staff were observing the patient from the nurse's office via a closed circuit television camera, with little or no direct contact. A sample of the patient's hourly observation sheets showed that at times, one member of staff only observed the patient. Over a ten-day period, staff had spent a total of ten hours face-to-face with the patient. On one date, the patient requested to go to the on-site café, however, there was a lack of staff to facilitate this. There was no evidence of the multidisciplinary team's consideration of the patient's reintegration to the ward. Two daily reviews by the responsible clinician were missing. There were no records of a periodic review by an independent senior professional. The three-month review of the patient by an external hospital was discontinued as the patient refused to speak with the doctor remotely. There was no evidence that any further attempts were made to engage with the patient.

The long term segregation paperwork for a Rose ward patient who was in long term segregation on Fairbairn ward, showed the paperwork met some, but not all the guidance in the Code of Practice. Staff had not recorded the roles of all staff involved in the decision for long term segregation. Staff were caring for the patient in the low stimulus and seclusion areas of Fairbairn ward, because there was no other suitable accommodation available. The patient had no access to secure outdoor areas. Staff had not informed the safeguarding team and the independent mental health advocate of the patient's long term segregation. We were unable to find reasons as to why this was the case. There was a lack of therapeutic intervention to end the patient's long term segregation. Whilst we noted two members of staff observed the patient within eyesight, we saw a period of two hours where only one member of staff was identified.

While we found clear rationale for the use of long term segregation for a patient on Prichard ward, we noted this would not end until commissioners identified a bespoke package of move on care. This meant the patient could remain in long term segregation indefinitely. However, there was evidence of commissioner involvement and agreement with this decision.

Staff took part in the provider's restrictive interventions reduction programme, which met best practice standards. Staff attempted 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.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

While 97% of staff had completed safeguarding adults and children levels 1 and 2 training and 84% of staff had completed level 3 safeguarding training, staff had not recognised or reported all safeguarding incidents.

25 out of 27 staff and seven managers, could explain how to protect patients from abuse. However, we found one financial safeguarding incident in patient notes on Robinson ward that staff had not recognised or reported as an incident or safeguarding concern. We raised this with the ward manager on day one of the inspection. Despite this, when we checked records at the end of our site visit (two days later) the manager had failed to report or process the safeguarding incident.

All staff and managers we spoke with could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff followed clear procedures to keep children visiting the ward safe.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and while patient records were easy to maintain staff told us that due to short staffing on the wards, they often had little time to ensure the records were of high quality. Other staff told us they sometimes forgot to complete daily care records when managers moved them from one ward to another during a shift.

When patients transferred to a new team, there were no delays in staff accessing their records.

Staff stored records securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure that staff did not control people's behaviour by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

The provider reported the following incidents:

From 1 April 2021 to 30 June 2021 there had been 38 incidents on Cranford ward; 59 incidents on Fairbairn ward; 22 incidents on Prichard ward; 16 incidents on Robinson ward and 83 incidents on Rose ward.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always share lessons learned from investigated incidents 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

While all 27 staff we spoke with knew of the providers incident reporting policy and could give examples of some incidents and near misses to report and how to report them, we could not be assured that all staff knew when to escalate a safeguarding incident such as the financial issue reported above.

Staff understood the duty of candour. They gave examples of when they had been open and transparent and gave patients and families a full explanation when things went wrong. Staff provided an explanation to the patient affected by the actions of staff causing him to have high potassium foods.

Managers debriefed and supported staff and patients after any serious incident. The service recently introduced a new way of ensuring staff received debriefing after incidents. We saw evidence of this effectiveness where debriefs with staff increased by 21% during the three weeks before our inspection.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations as appropriate.

Staff received feedback from the investigation of incidents, both internal and external to the service. There was evidence that managers made change as a result of feedback such as COVID-19 relating deaths, and recent assaults on staff by patients. Staff completed recommendations such as undertaking refresher courses in de-escalation strategies.

Managers shared learning about never events with their staff. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. The service experienced eight deaths during the first wave of the COVID-19 pandemic from which lessons were learned and implemented about correct use of personal protective equipment and isolation. However, on Cranford ward staff were not always using the wash room facility or sanitiser when entering and leaving the ward.

Are Forensic inpatient or secure wards effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission and produced individual personalised care plans for each patient. Five of the eighteen care plans we looked at were not complete and staff had not followed up on the progress notes.

We looked at 18 patients care plans and tracked through six patient care notes. Staff completed well formulated care plans for 13 out of 18 patients which included management plans for patients' identified risks and linked to the individuals positive behavioural support plans.

Staff did not always meet patients physical healthcare needs. Records showed that on three occasions staff had not followed a patient's specialist dietary care plan for kidney disease. Staff had given the patient food that on the third occasion caused a spike in his potassium levels leading to temporary paralysis of his limbs.

A second care plan showed a patient with a very high BMI, multiple physical health needs and a requirement for regular National Early Warning Score (NEWS) monitoring. However, the plan did not include any weight management interventions, and staff had not recorded the National Early Warning Score (NEWS) regularly between 13 June 2021 and 04 July 2021.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission, yet progress notes showed that staff did not always update care plans and implement care review changes in a timely manner.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. In most cases staff 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. Staff participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance such as National Institute for Health and Care Excellence.

Staff identified patients' physical health needs and recorded them in their care plans. Prichard ward introduced a cycling workshop giving patients' the opportunity to improve cycling ability and go out on their cycles when they use their grounds leave. As part of this project workshop staff encouraged patients to refurbish cycles for use in the programme.

Staff made sure patients had access to physical health care, including specialists as required.

In most cases staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. However, we found evidence of one patient who had not received foods in line with his dialysis care plan. The provider recognised this, addressed the issue with the patient and the staff caring for him provided a written apology to the patient.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes, including National Early Warning Score (NEWS), Health of the Nation Outcome Scales (HoNOS), Model of Human Occupation (MOHO) and Model of Creative Ability (MOCA).

Staff used technology to support patients, such as communication boards and language applications on smart phones and tablets.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Examples included making easy read versions of all care records to aid patients understanding, and development of a physical health passport for patients to retain as they move around and through healthcare services.

Managers used results from audits to make improvements, for example, the review of serious incidents audit to streamline the reporting process and link reports within the electronic database. A review of care records and an audit of observational records led to changes in ward recording processes.

Skilled staff to deliver care

The ward teams included or had access to the full range of 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. Managers provided an induction programme for new staff including agency and locum staff.

However, the recording of supervision processes offering staff opportunities to update and further develop their skills were not robust and we were not assured of the quality of staff supervision.

The service had access to a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right basic skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

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

Appraisal compliance rates at June 2021 were 100% on all wards except Prichard at 81%. We requested supervision data from the provider twice and this was not supplied, therefore we are unable to report on their supervision rates. The processes for recording supervision notes was not robust. We could not be assured about the quality or content of supervision for qualified and unqualified nursing staff. The providers policy did not require staff to keep any records of supervision, therefore it was not clear as to how the provider was assured that supervision enabled staff to carry out the duties they were employed to perform and how the provider continually assessed staff competency and capability. Fifteen of the 17 staff and four of the seven managers we spoke with confirmed they had supervision and reflective practice but ten felt the quality of supervision was poor and they could not necessarily recall what they discussed. No one had records or proof of what they discussed with their supervisor.

Members of the multidisciplinary team had their own effective professional supervision processes.

Managers told us that while they tried to hold regular team meetings, low attendance at the meetings due to staffing pressures on the wards meant that managers had to cancel some team meetings and others were not effective or meaningful. Our review of team meeting minutes across the service confirmed this. Managers told us that to ensure staff received all relevant key information they used staff e mail and staff handovers.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Requires Improvement

Forensic inpatient or secure wards

Multi-disciplinary and interagency teamwork

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 and engaged with them early in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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 and discharged these well. Managers made sure that staff could explain patients' rights to them.

Most staff kept up to date with training with 86% completing training on the Mental Health Act and the Mental Health Act Code of Practice. Twenty four out of 27 staff we spoke with, and all managers, could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

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.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when agreed with the Responsible Clinician and, or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. There were no informal patients on the wards we visited.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Requires Improvement

Forensic inpatient or secure wards

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves and understood the trust policy on the Mental Capacity Act 2005. Despite this, five out of six records we looked at staff had not clearly identified the capacity assessment and we saw no evidence of best interest meetings taking place.

Most staff kept up to date with training with 86% completing Mental Capacity Act training and 24 out of 27 staff and all managers we spoke with, understood the five principles.

There were seven deprivations of liberty safeguards applications made in the last 12 months and managers knew which wards made the highest number of referrals and staff monitored them correctly.

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 gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. However, staff had not clearly identified patient's capacity to consent in five out of six records we looked at. Three care plans did not have clearly identified capacity assessments, or best interest meetings, even though staff identified concerns around the patient's capacity to make informed decisions about some aspects of their health care needs.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

While there were systems in place for monitoring compliance with Mental Capacity Act processes this audit had not picked up the gaps in capacity to consent.

Are Forensic inpatient or secure wards caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff did not recognise that they were not respecting the privacy and dignity of a patient cared for in long term segregation on Fairbairn ward.

In most cases staff were discreet, respectful, and responsive when caring for patients. However, in respect of one patient staff cared for in prolonged seclusion on Fairbairn ward, the patient had to eat their meals off the mattress, floor or their

lap. We were concerned that this compromised the patient's dignity. We noticed the closed circuit television camera monitors for the seclusion room and en suite were switched on. We asked the doctor if the closed circuit television cameras could be turned off when the patient was using the toilet and it was safe to do so. The doctor told us that this was the provider's policy and there were not enough resources to assess that situation.

Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

We spoke with 17 patients.

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties, such as using word files, white boards, specialist electronic applications, Makaton and sign language.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care. Staff made sure patients could access advocacy services.

Involvement of families and carers

We spoke with four carers.

Requires Improvement

Forensic inpatient or secure wards

All carers confirmed that staff informed, supported and involved them appropriately.

Carers commented positively about their involvement with care planning, how staff kept them informed of their relative while at the hospital and the access and support they received from the carer's hub on the hospital site.

Staff helped families to give feedback on the service. Staff gave carers information on how to find the carer's assessment.

Are Forensic inpatient or secure wards responsive?

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Bed management

Data for June 2020 to June 2021 showed bed occupancy on the wards as Prichard 96%; Robinson 93%; Rose 92%; Fairbairn 99% and Cranford 70%. Managers held regular bed meetings to monitor bed occupancy and patients always had their bed available after periods of leave.

Managers monitored and reviewed length of stay for patients to ensure they did not stay longer than they needed to.

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

Staff only moved patients between wards when there were clear clinical reasons to do so, or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had variable numbers of delayed discharges in the past year as follows; Prichard six; Robinson nine; Rose three; Fairbairn one and Cranford five. Managers monitored the number of delayed discharges. The only reasons for delaying discharge from the service were clinical reasons.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients during referral to the ward or transfer between services.

The service followed national standards for transfer.

Requires Improvement

Forensic inpatient or secure wards

Facilities that promote comfort, dignity and privacy

While the design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity, the seclusion room on Fairbairn, where staff nursed a patient in prolonged seclusion, did not meet all his requirements. On the wards 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. Patients could access cold drinks and make hot drinks at any time subject to individual risk assessment, and while most wards had set snack times, staff could explain the rationale for this on grounds of overall patients' safety.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were only dependent on staff to make these when their risk assessment indicated this was not safe.

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.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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 made adjustments for disabled people and those with communication needs or other specific needs.

Wards were dementia friendly and supported disabled patients.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Requires Improvement

Forensic inpatient or secure wards

Managers made sure staff and patients could get help from interpreters when needed.

While the service provided good quality food, that met the dietary and cultural needs of individual patients. Five out of seventeen patients we spoke with said the food was not varied enough.

Patients had access to spiritual, religious and cultural support.

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.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and used the learning to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Forensic inpatient or secure wards well-led?

Requires Improvement

Leadership

Senior leaders were not always visible on the wards. Two managers told us they did not feel supported by senior leaders on matters such as staffing levels and recording supervision. These managers told us they felt senior managers did not fully appreciate the pressures faced by staff on the wards and their focus was on different priorities for the service.

However, at ward level, leaders had the skills, knowledge and experience to perform their roles but sometimes felt frustrated they could not rectify issues such as staffing levels. They had a good understanding of the services they managed, were visible on wards and approachable for patients and staff.

Requires Improvement

Forensic inpatient or secure wards

Vision and strategy

Staff could describe the provider values of Compassion, Accountability, Respect and Excellence and could evidence how they applied these values in their day to day work. However, they felt frustrated and could not understand why the organisation implemented yet another re-structure to create divisions, before giving the earlier restructuring a chance to prove itself.

Culture

Staff we spoke with did not feel respected, supported or valued by senior management. They acknowledged that the organisation had become better at promoting equality and diversity in daily work and the organisation provided opportunities for development and career progression. Staff felt senior managers still did not appreciate the work staff did or the pressures they were under because of insufficient staffing numbers on the wards. Staff described this impacted upon their physical and mental health and morale was low.

We completed seven manager and clinical nurse lead interviews. While all managers and clinical nurse leads acknowledged the serious issues with staffing and supervision and we saw how managers tried to escalate these issues to senior management on several occasions, they felt this had not been effective.

Governance

Governance processes were not always robust. Managers used governance dashboards and the provider held regular governance meetings with a clear framework of what was discussed and how this was fed back to staff, yet managers were not using monitoring systems effectively. This gave rise to the issues we found in the above key questions.

Managers were not monitoring and addressing issues of blind spots in all the ward courtyards, damaged staff emergency alarms, lack of handwashing when entering and exiting Cranford ward, or cleaning of shared equipment in the nursing offices. Managers were not monitoring completion of observation records or staff breaks from observation duties, seclusion paperwork or staff's adherence to care plans for people in seclusion or long term segregation. However, the provider had improved their monitoring of seclusion practices since the previous inspection in 2018. Managers were not monitoring the recording of capacity to consent and were not always able to ensure the privacy and dignity of a patient in long term segregation on Fairbairn ward. Managers were not ensuring that all registered nurses completed immediate life support training.

We could not be assured of the quality of supervision for nurses and healthcare support workers. The providers policy did not require staff to keep any records of supervision, therefore it was not clear as to how the provider was assured that supervision enabled staff to carry out the duties they were employed to perform and how the provider continually assessed staff competency and capability. We requested supervision data from the provider twice and this was not supplied, therefore we are unable to report on their supervision rates. This meant that there was no evidence when poor performance had been addressed, what support had been given to staff as part of their welfare or what advice, support or specialist training staff received to enable them to work with patients safely. Fifteen staff interviews confirmed they had regular supervision and reflective practice, but ten staff felt the quality of supervision was poor, they could not necessarily recall what they discussed and had no records or proof of what had been discussed.

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Requires Improvement

Forensic inpatient or secure wards

Management of risk, issues and performance

We could not be assured that all managers would recognise and identify all potential risk issues. While managers were aware of and addressed most risk issues that arose on the wards and addressed poor staff performance once they had become aware of it, due to the governance issues reported above we were not assured that all areas of risk would be identified and acted upon.

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

The provider had a directorate level risk register in place. The risk register matched the concerns of staff on the ward but had not addressed the main concern about staffing levels.

Information management

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

The provider used a dashboard system to collect data from the ward, and this was not burdensome on staff. The provider used key performance indicators to monitor the ward that included training, incidents and restraint.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

All wards were well equipped, well furnished, well maintained and fit for purpose. However, wards were not always clean or safe.

Safety of the ward layout

Staff had not identified all environmental risks and ways to mitigate them.

Staff could not observe patients on all parts of the wards. The ward gardens of Spencer North and Spencer South each had a blind spot where staff could not always clearly observe patients who accessed the far corners of the gardens. When we raised this with staff on the wards, they told us the blind spots were mitigated as staff would always accompany patients in the garden. However, during our inspection we observed multiple occasions where patients were not accompanied in the gardens by staff. Staff were not aware of these blind spots until they were raised during our inspection.

There was a potential ligature anchor point in the service that staff did not know about. Spencer South ward had a mirror in the bathroom of the accessible bedroom which had not been sealed effectively and presented a ligature risk for patients. However, this bedroom was not in use at the time of the inspection. The provider advised a review and risk assessment of the room would be carried out before a patient was admitted.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Staff did not always make sure the general cleaning records were up to date and the premises were clean. On Spencer North we observed staff had not swept the floor in the dining room after meals and there was food residue on the floor when we visited the ward on 6 July 2021. Staff told us this was because the ward cleaner was absent and ward staff were responsible for cleaning tasks that day. One patient told us the ward was usually clean. When we visited on the second day, we found Spencer North was clean.

Not all staff followed infection control policy and national COVID-19 guidelines. Staff had not completed touch point cleaning records on any wards and we did not observe any touch point cleaning during our onsite inspection. Touch point cleaning is regular cleaning of frequently touched areas and is required to be completed as part of the provider's response to the COVID-19 pandemic. When we raised this with staff on the day of the inspection, they informed us this used to be completed but was no longer necessary. This put patients and staff at an increased risk of infection from COVID-19. During the inspection, we observed seven staff from Spencer North and Spencer South not wearing face masks in accordance with national COVID-19 guidelines. For example, wearing their masks below their nose. However, all staff were bare below the elbows, hand sanitiser was available on all the wards and good hand hygiene posters were on display.

We found staff did not always follow food hygiene practices. Staff on Spencer North and Spencer South wards had not labelled opened food items in the fridge stating when they had been opened and when they should be consumed by. This continued to be a concern since our previous inspection in March 2018. This increased the risk of patients consuming food that has spoiled and not suitable for consumption.

Seclusion room

The seclusion room on Spencer South and Spencer North had toilet facilities, a visible clock and allowed two-way communication. However, when we visited, we found partial blind spots in both seclusion rooms of which the staff on the ward were not aware. These were in the toilet area in Spencer South's seclusion room and within the main area of Spencer North's seclusion room. Staff could only see a patient's legs and nothing above their waist. We also found the inside of the viewing pane had sharp edges within Spencer South's seclusion room. This increased the risk of patients harming themselves when using the seclusion facilities.

Clinic room and equipment

Spencer North and Spencer South clinic rooms were visibly clean and had enough space to prepare medication and undertake physical examinations. However, we found the clinic room in Berkeley Lodge was cramped and did not allow space for more than one person. Staff told us patient bedrooms would be used if a physical examination was required.

Staff calibrated and checked equipment weekly across all three wards to ensure physical health monitoring equipment was in good working order.

Emergency resuscitation equipment was not easily accessible on two of the three wards. Berkeley Lodge did not have emergency resuscitation equipment in the building. The nearest equipment was situated in Berkeley Close and required staff to cross a road and get through multiple locked doors. However, staff knew where to find the equipment if required. Spencer North ward did not have emergency resuscitation equipment on the ward. The nearest equipment was on Spencer South, which was in the same building but accessed through two air lock doors. Staff completed regular checks of the emergency equipment. All three wards did not have oxygen signs on the clinic room doors. The oxygen cylinder in Spencer North was not secured to the wall in the clinic room.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did have enough nursing and support staff to keep patients safe, but did not always have enough staff to meet patient preferences. The optimum staffing levels for Spencer North and Spencer South was two qualified nurses and four health care assistants. The optimum staffing for Berkeley Lodge was two qualified nurses and two health care assistants. The optimum staffing figure is the number of staff needed to meet people's needs. On Spencer North and Spencer South staff told us multi-disciplinary team members regularly supported ward staffing numbers to reach safe staffing levels. The safe staffing figure is the minimum number of staff needed to keep patients safe. Between 5 July 2021 and 9 July 2021, records showed that on two occasions multi-disciplinary team members needed to support the ward staffing numbers.

Patients had regular one to one sessions with their named nurse. The service had enough staff on each shift to carry out any physical interventions safely. Staff shared key information to keep patients safe when handing over their care to others.

The service had low staff turnover rates. Berkeley Lodge had a turnover rate of 2% and Spencer North and Spencer South had a staff turnover rate of 1% over the last three months.

Levels of staff sickness across all three wards was above 10%. There was a clear rationale for this level of sickness, and it was not service related. Senior staff from the division met daily to ensure staff sickness and shortfalls in staffing would be covered and there would not be an impact on patient safety. This included managing sickness which had been high during the COVID-19 pandemic.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency. Staff told us they had access to an on-call doctor who covered services during out of hours.

Mandatory training

Staff completed and kept up to date with their mandatory training. All three wards had mandatory training completion rates above 94%.

The mandatory training programme met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers told us they conducted a ward specific induction for new staff.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessing and managing risk to patients and staff

Staff did not always appropriately review risks to patients and themselves effectively. However, they achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly. However, we found patient risk assessments were not up to date with the most accurate information available because staff had not reported all incidents on the electronic reporting system. This meant important information relating to patient risks was not available to be considered as part of risk assessments.

Management of patient risk

Staff did not always act to prevent or reduce risks to, or posed by, patients. On Spencer South, we found staff did not always follow local policy and procedure to safely manage sharp items. We found staff did not always record when they had given sharps, including razor blades and scissors, to patients, and when they had been returned for safe keeping. We found an instance on Spencer South on 21 June 2021 where it appeared an item was missing, which was later returned, but there was no recorded evidence it was followed up to ensure there were no safety issues. This meant staff did not always have an accurate record of where sharps were located, which posed a risk for patients and staff. This was despite a recent serious incident which led to a review of sharps management.

Staff completed risk management plans for all patients. But we found incidents were not always reported and therefore risk management plans were not always updated after an incident occurred, this meant they were not always an accurate representation of what was needed to manage patient risks.

Staff followed organisational policies and procedures when they were required to search patients or their bedrooms to keep them safe from harm. Staff told us patient searches were carried out in line with the level of risk.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff had not used restraint for the previous three months across all three wards. Staff had not secluded any patients on Spencer South and Spencer North in the last three months. Staff had not used rapid tranquillisation in the last three months. Staff had not used long-term seclusion in the last three months. Staff told us there was clear guidance in place if this was needed.

Safeguarding

Not all 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, but they did not always know how to apply it.

All staff had completed level two in safeguarding adults and children. However, only 63% of staff on Spencer South completed level three safeguarding training and 60% of staff on Berkeley Lodge completed level three safeguarding training.

Spencer South staff did not always recognise safeguarding incidents and report them appropriately. The daily notes of one patient known to be a high risk of absconding included three incidents in May 2021 of temporarily leaving the location whilst on unescorted leave in the grounds. Staff had not reported these incidents on the electronic incident record or to the local authority safeguarding team.

Staff noted four safeguarding incidents in the daily notes of another patient on Spencer South between January 2021 and June 2021 which had not been reported on the electronic incident record or to the local authority safeguarding team. These incidents related to a known risk to the patient. This exposed patients and staff to a risk of harm as staff did not take opportunities to record, investigate and learn from incidents.

All staff we spoke to were able to state clearly how they would raise safeguarding concerns. Spencer North and Spencer South staff had access to a dedicated social worker, who was the local safeguarding lead for support in managing safeguarding concerns.

Staff followed clear procedures to keep children visiting the ward safe. Spencer North and Spencer South had a family visiting room with access to its own garden.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive, and staff accessed them electronically.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medication. Staff regularly reviewed the effects of medication on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medication.

Staff reviewed patients' medication regularly and provided specific advice to patients and carers about their medication. Staff told us they provided patients with easy read leaflets about their medication and encouraged them to read this before they started treatment.

Staff stored and managed medication in line with the provider's policy. However, we found prescribing documents needed to be archived as historic information was still stored with current records. One patient's medication record stated they were still on emergency medication which started in January 2021 even though this had previously been reviewed and discontinued.

There were no gaps in the administration records and staff discussed treatment plans with patients.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medication. Each patient had a ward round once a month where multi-disciplinary staff discussed and reviewed patient's medication.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance. We saw evidence of regular physical health checks on care records.

Track record on safety

The service had a variable track record on safety.

Berkeley Close staff reported four incidents in the previous three months. Spencer North staff reported 29 incidents in the last three months, although most incidents only involved verbal aggression.

Spencer South staff reported four incidents in the last three months. However, we found seven incidents in patient daily progress notes from January 2021 to June 2021 on Spencer South that staff should have reported.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well.

Staff did not always recognise incidents and report them appropriately. On Spencer South, staff did not record all incidents on their electronic incident reporting system.

When we asked to review the incident record system on Spencer South, one member of staff was unable to access the system and told us they cannot remember the last time they were required to do so.

Incidents not on the electronic reporting system were not investigated or reviewed.

We found learning from incidents was not always embedded across the service. Despite a recent serious sharps incident which led to changes across the service, we found staff did not always follow local policy and procedure to safely manage sharp items.

Staff understood their requirements under the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers offered support and debriefing to staff after any serious incident.

Staff met to discuss the feedback from incidents that were reported and look at improvements to patient care. All three wards had regular team meetings in place and the minutes were made available to all staff including those that could not attend.

Managers shared learning through lessons learnt across the organisation via emails titled 'Patient Safety Alerts'. These informed staff of incidents that have happened, what they have learnt from them and new practices which had been implemented as a result.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were personalised and holistic.

We looked at ten patient care records which were person centred. Records showed patients had a monthly ward round where all areas of care including therapy, leave, reported incidents and physical health were discussed before the patients care plan was updated. The records showed patients were involved in these monthly ward rounds and involved in their treatment plan.

Every patient record we looked at contained a positive behaviour support plan. A positive behaviour support plan is an individualised plan which is available to those who provide care and support aimed to reduce patient incidents before they occur by identifying early warning signs and de-escalation techniques. Staff involved patients in developing these plans.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. However, patients told us they were not able to always access these facilities due to staffing levels and training.

Staff provided a range of care and treatment suitable for the patients in the service. However, we were told by staff and patients that occupational therapists were often asked to assist the nursing team which prevents them from being able to provide treatments to patients. On Spencer South we saw an example in a patient's record that the patient was currently unable to take part in his prescribed relaxation sessions due to a lack of staff. On Spencer North we saw a record of when a patients music therapy session had to be cut short by 35 minutes due to staff not being available to escort them to the session.

Staff delivered care in line with best practice and national guidance. Staff told us they had a clear model of practice and treatment pathways.

Staff identified patients' physical health needs and recorded them in their care plans. All care plans we looked at had physical health needs recorded.

Staff made sure patients had access to physical health care, including specialists as required. Staff told us they had access to an on-call doctor 24 hours a day.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. A patient on Berkeley Lodge told us staff were able to meet his specific dietary requirements as a Muslim.

We found the activity room was used as a general-purpose room in Spencer North, including for the use of daily handovers and psychological therapy sessions. Patients on Spencer South told us they could not access the on-site pool as staff did not have adequate training to assist them. Patients raised this at both the May 2021 and June 2021 community meetings, but staff had not been able to support due to lack of courses. On Spencer North gym equipment could not be used as it was not serviced. Patients raised this in May 2021 community meetings. The provider advised the external company responsible for servicing the equipment was not able to attend site due to COVID-19 restrictions.

However, staff helped patients live healthier lives by supporting them to take part in programmes or giving advice using an Activities of Daily Living (ADL) kitchen.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff told us they used standardised tools to measure the effectiveness of interventions.

Staff used technology to support patients. Patients had access to computers and mobile phones. However, patients on Spencer North told us they could not always use the computer as there wasn't always enough staff to provide the required supervision.

Skilled staff to deliver care

The ward teams included, or had access to, the full range of 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 a full range of specialists to meet the needs of the patients on the ward. All wards had access to multi-disciplinary team including an occupational therapist, nurse, registered consultant and doctor.

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. Managers told us they could adjust their staff mix at daily divisional meetings to meet the patients' needs. However, when staff were moved it affected patient choice and access to activities and therapies.

Managers gave each new member of staff a full induction to the service and the ward before they started work.

Managers supported all staff through regular, constructive appraisals of their work. Staff told us they could approach management if they needed to.

Managers made sure staff attended regular team meetings or gave information from those that could not attend. All wards had regular monthly team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they could request additional training through supervisions. However, they did not have the time to complete this during shifts but could complete in their own time and claim the time back.

Multi-disciplinary and interagency teamwork

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. They had effective working relationships with staff from services providing care following a patient's discharge. However, we found staff did not engage with other agencies early in the patient's admission to plan discharge.

Staff held regular multi-disciplinary meetings to discuss patients and improve their care. Patients attended monthly multi-disciplinary ward rounds.

Staff did not always make sure they shared clear information about patients and any changes in their care. On Spencer South we found incidents had not been recorded and acted upon appropriately. However, staff told us each patient was discussed at handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff told us they worked well with external teams including the local authority.

Multi-disciplinary team staff did not plan discharge early in the patient's admission, which meant the patients care was not goal orientated. Five of the ten care plans we looked at did not have a discharge plan.

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 and discharged these well. 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. Over 92% of staff completed Mental Health Act training at the time of the inspection.

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. Staff told us they had access to the organisations policies through the shared area on the computer system.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. All three wards had advocacy information on display on patient notice boards.

Staff explained to each patient their rights under the Mental Health Act in a way they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The wards had an effective electronic system in place to ensure this would be completed on time.

Patients could not always access section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. Staff and patients told us the time that patients were able to take leave and the length of time of their leave was regularly affected by staffing levels on the wards. We were told, and observed during our inspection, that patient leave was organised for the morning of each day as staffing levels would be reduced in the afternoon due to staff being redeployed elsewhere in the service. We were told the redeployment of staff occurred daily. This meant that patients had a lack of choice and control over when they were able to take their prescribed leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to and recorded this clearly on patient records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed within the electronic care planning system.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff received and kept up to date with, training in the Mental Capacity Act and had a good understanding of at least the five principles. Over 92% of staff completed Mental Capacity Act training at the time of the inspection.

There was a policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff told us and records we looked at showed capacity assessments would be decision specific.

The service monitored through ward rounds how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Are Long stay or rehabilitation mental health wards for working age adults 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. We observed staff assisting patients to make their beds as part of their daily routine.

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported patients to access services in the community including opticians and dental services.

Patients said staff treated them well, were approachable and behaved kindly.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us they could speak to ward managers or the freedom to speak up guardian if they had any concerns.

Involvement in care

Staff involved patients in care planning and risk assessments and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us they were involved in monthly ward rounds and we saw person centred positive behaviour support plans within all care plans we reviewed.

Staff ensured patients had access to independent advocates. We saw notice boards on all three wards with information on how to access an advocate.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients could give feedback on the service and their treatment and staff supported them to do this. All three wards had regular community meetings in place. Areas discussed included activities and the environment and section 17 leave.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff told us they provided patients with easy read leaflets and encouraged them to read them before they started treatment.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff told us family involvement would be dependent on the patient's wishes. Carers told us they could call the ward if they had any concerns. Family members told us they were informed of their loved one's care and treatment and received regular updates from the ward.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff had not completed discharge plans in 50% of records reviewed. However, where records showed discharge plans were in place, staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

The low secure rehabilitation service was at 89% occupancy.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Monthly multi-disciplinary meetings reviewed length of stay and treatment plans.

The service had out-of-area placements as this was a specialist service.

Staff told us patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Five out of the ten care plans we looked at did not have discharge plans in place. Patients told us they were not aware of their discharge plans and were not clear how long they would be in hospital. We looked at two of the five discharge plans in place. These were detailed and planned with multi-disciplinary teams. Staff carefully planned the discharge and worked with care managers and coordinators to make sure this went well.

Where discharge plans were in place, the only reasons for delaying discharge from the service were clinical.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom within Spencer North and Spencer South ward. On Berkeley Lodge all patients had their own bedroom but shared two toilets and bathrooms between three rooms. There were quiet areas for privacy. The food was of a good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. All patient bedrooms had been personalised with the patient's items.

Patients had a secure place to store personal possessions. Every patient had access to a locker.

The service had quiet areas and a room where patients could meet with visitors in private. The wards had access to quiet areas and rooms.

Patients on all three wards had access to phones to make phone calls in private.

The service had an outside space that patients could access easily. Berkeley Lodge had a horticultural garden that the patients maintained.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients on all three wards had access to drinks and snacks throughout the day.

The service offered a variety of food. Patients told us they liked the food and when they did not, we saw patients making a joint complaint, supported by staff, which led to the service making changes.

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. Patients could carry out a range of activities through an an on-site centre called Workbridge including craft work, a café and garden centre. Patients also had on ward activities including horticultural sessions and bingo on Berkeley Lodge. The staff and patients on Berkeley Lodge told us they all participated in the weekly bingo session which was very popular.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff told us they had links to local businesses such as cafes and charity shops.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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 those with specific cultural needs. Patients had access to spiritual, religious and cultural support. On Berkeley Lodge one of the patients was assisted to attend a mosque every Friday and we saw a chaplain attending the wards during our inspection.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Notice boards on all three wards had a complaints policy on display. Patients we spoke to told us they could raise concerns if they had any.

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously, investigate them and learn 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. Carers told us they could call the ward if they had any concerns.

However, patients told us that not all concerns were acted upon by the service.

Patients on Spencer South told us they could not access the on-site pool as staff did not have adequate training to assist them. Patients raised this at both the May 2021 and June 2021 community meetings, but staff had not been able to support due to lack of courses.

On Spencer North gym equipment could not be used as it was not serviced. Patients raised this in May 2021 community meetings. The provider advised the external company responsible for servicing the equipment was not able to attend site due to COVID-19 restrictions.

The service clearly displayed information about how to raise a concern in patient areas. All wards had patient information boards including an easy read complaints policy.

Staff understood the policy on complaints and knew how to handle them. Staff told how they would raise complaints and concerns. When complaints were investigated lessons learned would be shared with the whole team and the wider service. These were shared through team meetings.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Ward managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. However, not all staff we spoke to were aware of the wider leadership team, such as who the Executive team were.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Ward managers had a good understanding of the service they managed. They could explain clearly how the teams were working to provide high quality care. Ward managers were able to explain the role of the multi-disciplinary teams. However, six staff told us the executive team were not visible in the service or approachable for patients and staff.

Vision and Strategy

Staff did not know and understand the provider's vision and values and how they were applied in the work of their team.

The provider's senior leadership team had not successfully communicated the provider's vision and values to the frontline staff in this service. Some staff told us they did not know what the provider's vision and values were.

Staff had the opportunity to contribute to discussions about the strategy for their service through team meetings and divisional meetings.

Culture

Not all staff felt respected, supported and valued. However, 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, but these were not always addressed.

Multi-disciplinary team members allocated to frontline shift work due to staffing shortages stated they felt devalued and not appreciated.

Staff raised concerns within team meetings and divisional meetings with gym equipment in Spencer North in May 2021 and again in June and July 2021, but this had still not been addressed by the provider. However, the provider advised the external company responsible for servicing the equipment was not able to attend site due to COVID-19 restrictions.

There was not always evidence that changes had been made as a result of feedback. Staff being moved to other wards to assist was raised at team meetings, but this had not been addressed.

Staff felt able to raise concerns without fear of retribution. All the staff we spoke to knew who the freedom to speak up guardians were. We saw posters on the wards showing staff how they could contact them.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that risk was not always managed well.

Not all actions identified in the previous inspection had been addressed in Spencer North and Spencer South. Both wards had food in the fridge that staff had not labelled stating when they had been opened and when they should be consumed by even though this had been raised within the previous report. This increased the risk of patients consuming food that has spoiled and not suitable for consumption. This action had been identified in the inspection report and had not been addressed.

Spencer South had a recent serious incident involving sharps and staff continued to not complete the sharps logs effectively, meaning staff did not know how many sharps (including razors and scissors) were stored in the cupboard and how many sharps were with patients. This had not been identified by the management team as audits were not completed.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The management team did not audit daily notes to ensure all incidents were reported and risks were assessed.

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

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

All staff had access to the organisations policies and procedures through the shared drive on the computer. Staff told us updates would be emailed to them and discussed at team meetings.

Learning, continuous improvement and innovation

The service had processes to ensure lessons were learnt from incidents through team meetings and patient safety alerts. However, we found evidence that not all learning from incidents was fully embedded on the wards which increased the risk of reoccurrence.

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all wards were clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

On Fern ward there was no fire extinguisher or fire blanket in the kitchen. Inspectors alerted the ward manager who advised they would address the issue. The provider told us a fire blanket had been made available.

Staff could not always observe patients in all areas of the wards. On Hawkins ward the view from the office into the communal areas was not clear due to scratched windows. In the long term segregation area on Marsh ward staff told us about a blind spot in the bedroom area. The blind spot was where the patient's bed was located, this did not allow staff to see the patient's full body and the head area was obscured. Due the patient's sensory needs he preferred the lights to be switched off. Staff told us and showed us that it was difficult to observe the patient through the viewing panel on the door. Staff told us they would listen for breathing and noise and if they could not hear anything, they would seek advice from the nurse in charge. Staff told us the blind spot and the viewing panel were reported to senior staff including the multi-disciplinary team and the chief executive. We also identified a blind spot in the long term segregation area bedroom on Meadow ward.

The wards complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried these on their belt and if activated pinpointed their location. Staff called for further assistance across the site using a radio.

Maintenance, cleanliness and infection control

Inadequate

Wards for people with learning disabilities or autism

Ward areas were not always clean, well maintained, well-furnished and fit for purpose. On Fern ward cleaning records were not up to date. On Acorn ward the kitchen was not clean and we found omissions in cleaning records and no evidence of touch point cleaning for COVID-19. On Hawkins ward we found broken fixtures and fittings.

We reviewed monthly cleaning audit records provided for all wards from April 2021- June 2021 inclusive. Two wards scored below 95% (minimum pass rate). This was Berry ward in June 2021 scoring 83% and Sunley ward in May 2021 scoring 94.7%. We reviewed infection prevention and control audits from April- June 2021**.** The provider advised that Fern is the only ward with a completed infection prevention and control audit during this time. The rest of the wards are scheduled to be completed over the next year. Staff completed Fern's infection prevention and control audit in April 2021 and the ward scored an overall compliance of 91%.

Staff did not always follow infection control policy. On Sunley ward we found out of date and opened, unlabelled food in the kitchen fridge. Staff had not recorded fridge temperatures every day as required, between 09 June 2021 and 07 July 2021 we found six days missing. On Acorn ward we found expired food items in the fridge and cupboard; staff had not always completed fridge temperature checks and when they had checked there were three out of seven days when the fridge temperature was too high; staff did not always check the temperature of hot food. On Hawkins ward we identified a worn-out chair that posed an infection risk; we found the laundry room to be disorganised with piles of clothes and staff unable to describe how they managed the laundry.

Seclusion room

Not all seclusion rooms allowed clear observation and two-way communication. They all had a toilet and a clock

Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice. We checked the seclusion room on Sunley ward. Staff were unable to operate the intercom to allow for two-way communication between staff and a patient. There was a potential ligature risk on the en suite door, however, staff told us this was low risk as a patient occupying the room was always observed by staff. There were stains on the ceiling of the seclusion room. There was a metal, combined toilet and hand-basin. The nurse manager told us that there had been no problems with this facility.

We viewed the long term segregation areas on Marsh and Meadow wards. These areas consisted of a bedroom, en suite area, lounge area and an small secure courtyard to enable the patient to get some fresh air. There was an observation area where staff were provided with seating. There was no actual access to the outside. On Meadow ward the only storage the patient had was drawers located at the bottom of the bed. There was no table therefore patients were expected to use their mattress, floor or laps. However, on Marsh ward the staff had a board that contained important information about the patient such as the correct pronouns to use and the topics of conversation the patient enjoyed engaging in. The staff had access to flasks, radio, iPod, and a drawer that had the patient's property. There was also a games console. This meant staff could easily provide the patient with items without any delays. In the lounge area there was a sofa, table, chair, a television (in a locked Perspex box) and books.

Clinic room and equipment

Clinic rooms were not all fully equipped. On Acorn ward one oxygen cylinder was less than half full and surplus oxygen cylinders were not chained to the wall. Staff did not always check equipment. Staff were not completing checks of emergency equipment on Sunley ward. However, clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly

Inadequate

Wards for people with learning disabilities or autism

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients well. Staff did not always receive basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. On Meadow ward we reviewed three incidents reporting unsafe staffing levels which took place in June 2021. Staff recorded in one incident report that "During the day the ward had to use non MAPPA trained staff on enhanced support when the patient was awake. Patients' requests were facilitated with delays or not at all". On Meadow ward we observed the nurse in charge advise Acorn ward they were unable to send staff to respond to an incident as they would be below safe numbers. On Fern ward we reviewed staffing on the provider's dashboard which showed that on 24 days between 9 June 2021 and 8 July 2021, the ward did not achieve safe staffing levels and between 9 May 2021 and 7 July 2021 (60 days) – there were 39 days (65%) that did not reach safe staffing levels. There was no mitigation to minimise risk in any of the examples where staffing fell below the required levels. Over the same period, there were no days which reached optimum staffing. Staff we spoke to said that even if optimum staffing levels were reached, staff would then be moved to support other wards. On Sunley ward we reviewed staffing from 8 June 2021 – 7 July 2021 (30 days) on the provider's dashboard which showed 22 days (73%) when staffing levels were not optimum. During this period there were three days (10%) when staffing levels fell below safe levels. The ward had the lowest number of staff on 7 July 2021, when there were seven staff (this is despite the fact that eight staff members were required to meet safe staffing and nine for optimum), we were told three staff had been redeployed to support other wards; we observed staff discussing being low on numbers and waiting for staff from another ward and one staff being sent to another ward to respond to an incident leaving the ward below safe numbers. On Hawkins ward we reviewed staffing on the provider's dashboard. This showed that in the last two months (May-July 2021) there had been 36 days when staffing was not optimum and 24 days when staffing fell below safe staffing levels. 22 staff and 11 patients told us the wards were short staffed. On Marsh ward we reviewed community meeting minutes for 23 June 2021 which stated there was no meeting the previous week as no staff were available to facilitate. At the same meeting patients raised concerns about low staffing in the afternoons and no staff being available to respond to an incident. We reviewed minutes for six meetings between April and June 2021 where staffing shortages and/or skill mix were raised as an issue on Meadow, Marsh, and Berry wards. We reviewed divisional clinical governance meetings for June 2021 which stated "patients are keen to do more activities but this is minimal due to staffing."

The vacancy rate for staff varied across wards. The provider reported a qualified vacancy rate of 30% as of July 2021. Brook reported the highest rate at 46% and Sunley the lowest at 13%. The provider reported a fill rate of 124% for unqualified staff. Meadow reported a 9% vacancy rate and Brook a 7% vacancy rate.

The service reduced its use of agency staff. The provider reported agency staff were used to cover 3% of all shifts between 1 April 2021-30 June 2021.

The service increased its use of bank staff. The provider reported bank staff were used to cover 27% of all shifts between 1 April 2021-30 June 2021.

Managers told us they tried to request staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates. The provider reported a turnover rate of 1.3% between 1 April 2021-30 June 2021.

Managers supported staff who needed time off for ill health. Levels of sickness were high. The provider reported a sickness rate of 10% of between 1 April 2021-30 June 2021. This was highest on Fern ward with 17% and lowest on Sunley ward with 6%.

Divisional leaders did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Ward managers and multi-disciplinary team members were required to cover shifts. The provider reported that multi-disciplinary team members supported 48 shifts of 182 shifts between 1 April 2021-30 June 2021 which totals 23%.

The ward managers could adjust staffing levels according to the needs of the patients.

Staffing levels did not allow patients to have regular one to one sessions with their named nurse.

Patients regularly had their escorted leave, therapies or activities cancelled or cut short because of staff shortages. Seven patients told us they had their escorted leave or activities cancelled due to the wards being short staffed. Eleven staff told us they had to cancel patient escorted leave or cancel activities due to the wards being short staffed.

We reviewed examples in care records of patient care being impacted by staff shortages. On Meadow ward a patient access to an electronic tablet was not facilitated at the planned time due to low staffing on 2 July 2021; on Marsh ward a patient's education session was cancelled on 19 July 2021 due to staff having to cover another ward. On Marsh ward we reviewed two incidents (one December 2020 and one March 2021) where a patient was secluded in the extra care area due to there not being enough staff to safely support them (the patient was prescribed 2:1 staff observations but only one staff was available).

We reviewed 24 community meeting minutes between 1 April 2021 and 30 June 2021 and at 11 of them patients raised concerns about the impact of staff shortages on access to leave, therapies and activities.

We reviewed divisional clinical; governance meeting minutes for April 2021 which stated "As we start to reintroduce leave, we need to get the message across about the ongoing staffing issues and the difficulties we may face with getting people out on leave".

The service did not always have enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

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.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Not all staff completed and kept up to date with their mandatory training. The provider reported a mandatory training rate of 95% for the Men's learning disability and autism wards as of 5 July 2021. The provider reported compliance of 75% or below for the following courses and wards- Safeguarding level 3: Acorn- 67%; Hawkins- 71% and Marsh 75%. Immediate life support/identifying a deteriorating patient- Acorn- 70%; Hawkins- 71% and Marsh 75%. National Early Warning signs: Marsh- 73%. Effective record keeping: Sunley- 73%.

The mandatory training programme was comprehensive but did not meet the needs of patients and staff. Learning disability and autism training was not mandatory for these wards

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. However, staff had the skills to develop and implement good 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 failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission and did not always review these regularly, including after any incident. On Marsh ward we reviewed a patient's records and found the risk assessments were incomplete, staff completed an initial comprehensive assessment and detailed risks including threats to kill, however these were not included in the Positive Behaviour Support or other care plans. On Fern ward we reviewed seven patient records, staff completed risk assessments for all, however only two were up to date. One patient's risk assessment was last updated in March 2021, since then 19 incidents had occurred, but staff had not updated the risk assessment. Another patient's risk assessment was updated in February 2021, 38 incidents had occurred since then including one incident requiring police intervention.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others.

Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy.

On Hawkins ward staff were completing enhanced observations of patients for more than two hours. We reviewed four shift planners for July 2021 and found that staff were allocated to enhanced observations for more than two hours on 23 occasions. On Hawkins ward on 6 July 2021, CQC staff witnessed staff not completing observations of a patient as prescribed. We also identified that staff were allocated to enhanced observations and response duties at the same time on seven occasions on the 5 July. On Acorn ward, we observed one staff on enhanced observations for six hours during our inspection visit on 8 July 2021 and we reviewed four shift planners for July 2021. We found staff were allocated to enhanced observations for more than two hours on seven occasions. On Marsh ward, we reviewed six shift planners for

June 2021 and July 2021. We found that staff were allocated to enhanced observations for more than two hours on 36 occasions. On Meadow ward, we reviewed six shift planners for June 2021 and three for July 2021. We found that staff were allocated to enhanced observations for more than two hours on 16 occasions. We identified five occasions when staff were allocated to patient enhanced observations and other activities.

This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

On Sunley ward we reviewed a sexual safety incident between two patients and the investigation found that the opportunity was presented due to one of the patient's observing staff not being present as required. We identified discrepancies between two other patients' care plans and the interventions recorded in their progress notes and in other records. This included a discrepancy in the enhanced observation levels for one patient.

On Hawkins ward we reviewed records for a patient on 3:1 eyesight observations, the patient fell and sustained a cut requiring seven stitches. Staff recorded that they noticed bleeding but did not witness the fall. We reviewed the incident report and there was no mention of the patient being on enhanced observations. For the same patient we found the following recorded in clinical governance meeting minutes from January 2021 "In times of critical staffing levels, x is nursed on 2:1 in line with ward contingency plan".

On Marsh ward staff continued to, on occasions, fail to fully complete observation records.

The provider reported 47 incidents of patients self harming whilst on enhanced observations between 1 April 2021-30 June 2021. 11 of these occurred whilst patients were on arms-length observations. Marsh ward reported the most with 14 (all eyesight observations), Meadow ward reported the least with three (one arms- length and two eyesight). Enhanced observations aimed to reduce the likelihood of a patient being able to harm themselves.

A senior leader told us that staff did not always understand the reason they needed to observe a patient.

Staff were not always following the providers safety procedure for checking cutlery in and out. On Meadow ward we reviewed cutlery checking in/out forms for June 2021 and seven days were missing, many of the forms were not signed and a spoon went 'missing' on 8 June 2021 and was still missing the next day. The spoon was later found but this was not reported as an incident. On Acorn ward staff did not always complete cutlery checks and were unclear on actions to be taken when items of cutlery were missing.

Senior staff reported that staff still need to work on professional boundaries and appropriate relationships following several serious incidents involving a patient accessing contraband items.

Whilst we found no blanket restrictions in place on the wards, we identified blanket restrictions imposed on patients nursed in seclusion. On Acorn and Berry wards staff told us patients were only allowed paper or silicon plates and finger food when being nursed in seclusion. They told us no cutlery (metal or plastic) was permitted when patients were secluded. This was a blanket restriction that was not individually risk assessed.

Use of restrictive interventions

Levels of restrictive interventions were reducing. The provider reported 135 restraints between 11 April 2021-30 June 2021. Acorn reported the most with 36, followed by Hawkins with 33. Meadow reported the fewest with three. Of the 135 restraints seven were prone restraints.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using verbal de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. The provider reported four uses of rapid tranquillisation between 1 April 2021-30 June 2021. Three on Fern ward and one on Acorn.

The use of seclusion decreased. The provider reported 36 seclusion incidents between 1 April 2021-30 June 2021. Brook reported the most with ten followed by Sunley with eight.

The provider reported two incidents of long-term segregation between 1 April 2021-30 June 2021, one on Marsh ward and one on Hawkins ward.

When a patient was placed in seclusion, staff did not always follow best practice guidelines. We reviewed the records of a patient on Hawkins ward was subject to seclusion from 14 November 2021 following a violent incident where harm was caused to staff. We identified a number of issues. We noted, on the day the patient's seclusion commenced, an on-call responsible clinician, at 22:00, said the patient should remain in seclusion overnight. Further entries suggested seclusion should not be ended until the multidisciplinary team review, two days after the seclusion commenced. The patient had no exit plan from seclusion whilst they awaited transfer to a high secure hospital. The patient had periods where their interaction with staff did not meet the requirement of the code of practice for seclusion to continue, staff described the patient as 'settled' and engaging. The patient's most recent incident involving violence and aggression was recorded on 11 March 2021. The multi-disciplinary team proposed access to fresh air in a review on 1 December 2020, 16 days after seclusion commenced. The patient's positive behavioural support plan did not recognise strengths but reflected deficits such as "I am still a risk of self harm as well as aggression towards others". The seclusion care plan reflected punitive language such as "the patient must demonstrate a recognition of the seriousness of their behaviour". The patient's access to a laptop was distorted by the damaged observation panel between the ward observation office and the seclusion room, this meant they could not use the laptop. In April 2021, the multidisciplinary team felt the patient's ongoing seclusion may increase their frustration and risk of violence. The multi-disciplinary team review dated 6 July 2021 indicated that funding had been agreed to offer support in an extra care environment, however the "ward was unable to implement any special package involving extra care" which would have improved the quality of life for the patient. Staff told us the area used to nurse patients in long term segregation was not in use but reserved for potential use by another patient.

Staff did not always follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

We reviewed records for a patient nursed in long term segregation on Marsh ward. Staff recorded that long-term segregation would end when a bespoke placement was identified. This meant the patient could remain in long term segregation indefinitely. However, there was evidence of commissioner involvement and agreement with this decision. A care programme approach review took place on the 23 March 2021 with no record that a bespoke placement was

discussed. One approved clinician review dated 6 June 2021 lacked detail merely stating "2:1 LTS, necessary and proportionate to manage risk continue". We found gaps in the weekly multidisciplinary reviews from the 26 April 2021 to 2 July 2021. An external review was cited in the progress notes dated 26 June 2021 but we were unable to locate this. However, we found an external review dated 15 March 2021 that stated there was no clear exit strategy and that the care team needed to be clear about the care pathway. Furthermore, it recommended a review of the rationale for long term segregation, review of the patient's sensory needs, engagement in occupational therapy activities and staff to explore further if the patient had post traumatic stress disorder and offer appropriate treatment. We did not see evidence of how these recommendations were being followed. We reviewed the long term segregation care plan for this patient and it stated the patient needed to be observed due to risk to himself. We were concerned currently staff are unable to do this due to blind spots.

We reviewed records for a patient nursed in long term segregation on Sunley ward. Staff had not recorded the roles of staff involved in the decision for long term segregation. Staff attached a new positive behaviour support plan to the patient's long term segregation care plan. However, the care plan referred to a different ward, so it was unclear what was still current in this plan. We looked at a sample of the recording of the patient's hourly observations over 14 days. We noted gaps in the recordings for 64 hours during this period. We also noted the patient was observed by one member of staff as opposed to two for one hour during this period. There was no record of which staff completed the patient's observations for eight hours on one day. The criteria to allow the patient's long term segregation to end was a bespoke placement in the hospital's grounds, however, there were no updates in the patient's records about this. We were unable to find any records of a periodic review by an independent senior professional or a three-month review of the patient by an external hospital in the past six months. The provider advised that review documents were available at the time of the inspection but these were not provided as part of the draft report review process.

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 mostly kept up to date with their safeguarding training. The provider reported as of June 2021 permanent staff across all wards had a compliance rate of 97% for safeguarding level one and two training and 80% for level three safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Each ward had a dedicated family visitors' room within the building which could be booked in advance so managers can ensure staff are available to attend.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

On Sunley ward we identified two open safeguarding incidents dating back to 2018. Staff raised concerns that a member of staff had been moved to the ward following an incident of neglect on another ward. This staff member was not supposed to work unsupervised but was working alone to cover colleagues' breaks.

Staff did not make safeguarding referrals when patients were cared for in long term segregation. We found no evidence of this.

Managers did not take part in serious case reviews and make changes based on the outcomes. We found no evidence of this.

Staff access to essential information

Staff had easy access to clinical information. Staff maintained electronic high quality clinical records. However, paper copies were not always up to date.

Patient notes were comprehensive, and all staff could access them easily.

The service used a combination of electronic and paper records across both wards.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service systems and processes to prescribe, administer, record and store medicines were not always safe. Staff regularly reviewed the effects of medicines on each patient's physical health. Not all staff knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines.

On Marsh ward staff had not signed and dated patient T2 and T3 forms and four patient's forms still had the previous ward as their address.

On Fern ward we identified issues with medication returns being signed for. The pharmacist had not signed one form on 29 June 2021 and on 31 January 2021 there was no pharmacy signature and both copies were still present for a return containing codeine, diazepam & fluoxetine. We raised this with the provider who provided immediate assurance that the medication had been returned to pharmacy. We found two boxes of expired needles, one box expired May 2021 and the other June 2021 and we identified nine days in June 2021 when staff recorded the temperature of the medicines fridge as above eight degrees with no evidence of action taken to address.

One doctor we spoke with was not familiar with STOMP (stopping over-medication of people with a learning disability, autism or both). A senior leader advised that they reported to the provider's executive committee on the service alignment to STOMP (stopping over-medication of people with a learning disability, autism or both).

On Acorn ward doctors prescribed two patients anti psychotics above the British National Formulary limits, we saw that staff completed care plans and additional health monitoring for both patients in line with guidance.

On Sunley ward we spoke with a nurse who was not aware of a spare set of medication keys. Staff had not completed the controlled drug book index. We found inaccurate records in the controlled drug book; staff recorded 102 tablets

instead of 100. Two staff were unable to describe how to escalate/investigate any controlled drug concerns and there was no evidence that controlled drugs were disposed of in line with local policy. Staff were not checking stock expiry dates and we found expired items. Staff had not recorded the temperature of the medicine fridge on 3 and 4 July 2021. Staff were not completing audits of temperature checks of the medicine fridge.

On Hawkins ward staff recorded the medicine fridge as being over eight degrees for seven continuous days from 25-31 May 2021. Staff had not recorded the fridge temperature for three days in April 2021, eight days in March 2021, six days in February 2021 and two days in January 2021. We found expired items including sterile swabs, blood collection bottles, sterile saline and blood testing kits. The weekly clinic checks did not include checking expiration dates of surplus stock.

Staff did not always review patients' medicines regularly. On Acorn ward staff had not reviewed five patients' as required medication for more than 14 days.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All patient medication administration charts are stored on an online computer system.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Not all staff at the service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both). On Fern ward medical staff were not familiar with STOMP (stopping over-medication of people with a learning disability, autism or both). However, a senior leader advised that they reported to the provider's executive committee on the service alignment to STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Clinical Excellence guidance.

Track record on safety

The provider reported the following incidents:

The provider reported 536 incidents for this service between 1 April 2021-30 June 2021. Fern reported the most with 110, Meadow reported the least with 18. The most common incident type across all wards was 'Physical aggression and violence' accounting for 222 reported incidents.

The provider evidenced sharing of national safety alerts and action taken to ensure wards acted as required.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers usually 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.

Inadequate

Wards for people with learning disabilities or autism

Staff did not know what incidents to report and how to report them. Staff did not always raise concerns and report incidents and near misses in line with provider policy.

On Acorn ward we reviewed patient progress notes, care plans and incident records from 1 January 2021 for three patients. We identified 20 incidents in progress notes that were not reported on the provider's incident reporting system. Some of the incidents which were not reported as incidents were of significant concern, including inappropriate sexual behaviour and incidents of self harm which were a known risk for the patients. One patient's positive behaviour support plan incorrectly stated the patient had not self-harmed whilst on the ward.

On Meadow ward not all identified risk incidents had been reported on the incident reporting system. Across the five patient records checked we identified 15 risk incidents that had not been reported. We also reviewed cutlery checking in/out forms for June 2021 on Meadow and identified an incident where a spoon had gone missing which was not reported as an incident.

On Marsh ward we reviewed a patient's records and found staff recorded for the most recent care review meeting "several risk issues including sexually inappropriate behaviour, racially motivated verbal abuse, threats of violence and attempted physical violence" however, staff only reported four incidents since the patient's admission three months ago. We reviewed another patient's record and identified an incident of self harm resulting in injury that staff had not reported as an incident.

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

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.

Managers debriefed and supported staff after any serious incident. We observed a debrief on Fern ward and staff were well supported.

Managers investigated incidents thoroughly. However, on Hawkins ward we reviewed three incident reports, one serious incident investigation was overdue and still being reviewed, the other two had no outcomes or preventative measures and one was overdue.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Inadequate

Wards for people with learning disabilities or autism

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients to develop individual care and support plans, and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and strengths based. However, staff did not always involve families and carers.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward and had an up-to-date hospital passport.

Staff developed a comprehensive care plan for most patients that met their mental and physical health needs.

Staff regularly reviewed and updated most care plans and positive behaviour support plans when patients' needs changed. We reviewed 31 patient records and identified two where staff had not completed or updated the patients plans. On Marsh ward staff had not completed and updated one patient's care plan and the positive behaviour support plan contained limited information. On Hawkins ward staff completed a poor-quality positive behaviour support plan for a patient, with a strength identified as the patient still being at risk of self harm.

Most care plans were personalised, holistic and strengths based.

Positive behaviour support plans were present and supported by a comprehensive assessment.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. Staffing shortages meant that access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation was at times, limited. Staff did not always support patients with their physical health.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff did not always provide a range of care and treatment suitable for the patients in the service. Therapy staff covered more than one ward and described being stretched with one therapist advising if the wards were fully occupied, they would not be able to support all patients.

Managers were continuing to allocate therapy staff to frontline shift work due to staffing shortages which impacted on the delivery of therapies to patients. Across all wards seven patients and 11 staff raised concerns that required therapies were not always being provided.

On Fern ward multi-disciplinary team members reported being used in the numbers and receiving weekly emails telling them they have to cover shifts. We reviewed the weekly timetable, four patients had days with no activities, the maximum activity time for any one patient in one day was three hours, the majority of patients would have one x one hour activity per day. One staff told us they rarely see the multi-disciplinary team and there was no point in patients doing psychology as psychologists keep leaving and patients haven't had therapy for months which is impacting on their progress and lengthening their hospital stay.

Inadequate

Wards for people with learning disabilities or autism

On Sunley ward we reviewed a patient's progress notes for 21/01/2021 which stated "X engagement with the multi-disciplinary team has been impacted by the multi-disciplinary team being redeployed into nursing numbers". Senior staff advised therapy staff are pulled into numbers.

On Hawkins ward staff told us that multi-disciplinary staff are sometimes pulled into ward numbers.

On Acorn ward multi-disciplinary team members reported being pulled in to staffing numbers regularly, which prevented them being able to carry out therapies. This led to a backlog which at times prevented patients from receiving timely treatment. Therapy staff were asking patients to attend remote sessions due to a lack of available staff. We saw from patient records that patients were refusing these sessions. We were told by a patient this was because they didn't like the remote option.

On Marsh and Meadow wards multi-disciplinary staff told us there are lots of staffing issues limiting activities that can be offered.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg National Institute for Health and Care Excellence).

Staff understood patients positive behavioural support plans and provided the identified care and support.

Staff did not always identify patients' physical health needs and record them in their care plans. Staff did not always make sure patients had access to physical health care, including specialists as required.

On Sunley ward we reviewed a physical healthcare incident that occurred on 8 May 2021. Staff did not respond appropriately, and the patient was left all night without required interventions and was eventually taken for treatment in hospital the next day. Medical staff signed and dated a DVT/Venous thrombosis risk assessment for a patient but had not completed any details on the form.

On Hawkins ward a patient told us they have been waiting three years for a hearing test. Another patient had swollen ankles and reported this had been on-going for a few weeks, the patient had required medical intervention, but staff had not updated the patient's care plan to reflect this new physical health care need.

Staff met most patients' dietary needs and assessed those needing specialist care for nutrition and hydration. On Marsh ward staff had not fully completed patient food and fluid charts.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. However, the provider reported on BMI outcomes for June 2021 and the learning disability and autism wards (including female wards) were a considerable outlier with over 20% of patients in the extremely obese range.

The provider advised their physical health team were available for routine and urgent referrals between 08:00 and 20:00, seven days per week. Patients could access on site dentists, podiatry and GP's.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients.

Managers took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

Managers did not always make sure they had staff with the range of skills needed to provide high quality care, or offer opportunities to staff to update and further develop their skills. Most ward teams included or had access to the full range of specialists, however, they were not always able to meet the needs of patients on the wards. Managers supported staff with appraisals. Managers provided an induction programme for new staff.

The service mostly had access to a full range of specialists, however, they were not always able to meet the needs of patients on the wards due to being redeployed into frontline staffing numbers. Multi-disciplinary team members told us they were not able to perform their roles, including statutory duties under the Care Act, due to being required to cover frontline shifts. We reviewed nurse manager meeting minutes for June 2021 which stated Meadow and Marsh wards had no occupational therapist since November 2020. The provider advised that occupational therapists are in post but have been non patient facing due to long COVID.

Managers did not make sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including non-permanent and agency staff. Managers did not make sure staff received any specialist training for their role. We were told that non-permanent staff were split into divisions across the hospital and non-permanent staff in the learning disability and autism division did not require learning disability or autism training. This meant that staff could be working with patients without the knowledge or skills in order to support patients with their required needs.

However, the provider reported a total of 541 specialist training courses had been completed by staff in the service between 1 April 2021 and 30 June 2021. Examples included the certificate in Mental Health, cyber security awareness, collaborative risk assessment, dysphagia, transgender awareness, banter in the workplace, search training, an introduction to positive behaviour support and the importance of physical activity. The provider reported 29 permanent staff across all wards completed an ‘introduction to autism’ course; 15 staff on Brook ward, 10 on Meadow, three on Marsh and one on Hawkins.

Managers gave each new member of staff a full induction to the service before they started work. The provider reported that all required staff completed an induction between 01 April 2021 and 30 June 2021. Senior leaders advised they were introducing a specialist learning disability and autism induction.

Managers supported staff through regular, constructive appraisals of their work. As of 24 May 2021, the overall appraisal rate for staff within this service was 100%.

We requested supervision data from the provider twice and this was not supplied, therefore we are unable to report on their supervision rates. We were advised the current compliance rate for management supervision on Meadow and Marsh ward was 100%. Marsh reported 62% for clinical supervision between April 2021 and June 2021 and Meadow reported 89%. However, there were no examples available for us to review during our site visit. On Hawkins ward we were told clinical supervision rates for past six months averaged at 44% per month, ranging from 0% to 83%.

We are unable to report on whether managers ensured staff attended regular team meetings. We requested staff meeting minutes for April 2021 to June 2021. The provider sent minutes of four meetings for Berry ward, two for Marsh two and two for Meadow two (Marsh and Meadow opened in April 2021). No minutes were provided for the other wards.

Managers tried to give staff the time and opportunity to develop their skills and knowledge. Staff told us that access to training had been impacted by the pandemic.

Managers recognised poor performance, could identify the reasons and dealt with these. The provider advised that "a capability policy and procedure is in place to support managers with managing poor performance. The majority of cases are managed informally and managers are supported by an employee relations 'manager's toolkit' where there is guidance and templates on improvement plans. A central employee relations team will support any formal cases and there is currently one on Berry ward."

Multi-disciplinary and interagency teamwork

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 staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and their care.

Staff did not always ensure they shared clear information about patients and any changes in their care, including during handover meetings. On Sunley ward we observed staff handing over information regarding a patient stating, "I wish I could help you guys understand this patient but he's so complicated". We observed a staff member arrive from another ward to support the ward and they stated they were unfamiliar with the ward. Staff gave a brief handover and allocated them to bedroom corridor observations.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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 and discharged these well. 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. Permanent staff across all wards had a compliance rate of 94% for Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time.

Staff did not always facilitate patients taking section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

On Sunley ward patients were allocated a day per week for section 17 leave as the ward manager advised they would be unable to facilitate in any other way due to staffing. We reviewed records for one patient who missed their leave on four out of nine weeks.

On Acorn ward we observed a ward round- one patient requested unescorted ground leave and this was denied with reason given by psychologist as "no rationale for unescorted grounds leave".

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act, in relation to detention and rights, correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Permanent staff across all wards had a compliance rate of 94% for Mental Capacity Act and Deprivation of Liberty training.

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 gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Inadequate

Wards for people with learning disabilities or autism

The service monitored how well it followed to the Mental Capacity Act and acted when they needed to make changes to improve.

Are Wards for people with learning disabilities or autism caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness. However, staff respected patients' privacy and dignity. They did not always understand the individual needs of patients but tried to support patients to understand and manage their care, treatment or condition.

Staff did not always treat patients with compassion and kindness.

On Meadow ward we found examples in one patient's care records where staff repeatedly referred to the patient as being "demanding". We reviewed ten entries in the patient's progress notes between April 2021 and July 2021 that stated the patient was "making allegations, demanding and rude".

On Sunley ward we identified use of a punitive approach in one patient's care plan- "Staff will not engage in conversation with patient in low stim. This is an opportunity for him to reflect on his behaviour. Once he has done this he can return to the ward." We overheard a staff member talking in a discriminatory manner about a patient "Yeah, it's just x playing up". One staff described "managing difficult patients", one staff described patients as "a very needy client group", one staff described the patients as "ganging up".

On Hawkins ward staff advised regarding a damaged chair observed during tour of the ward "that's what you get for giving patients their own keys". The same staff also commented that "it's a battle when you have to try and be least restrictive". One staff told us they witnessed "sharp words" from staff to patients. There was no table in the seclusion room from which the patient in seclusion could eat their meals. This meant the patient balanced their meals on their knees whilst eating. We noted the patient occupied the seclusion room since November 2020. Four patients on Hawkins ward told us that some staff (mainly night staff) were rude and sometimes spoke in a different language.

On Marsh, Acorn and Berry wards we found that closed circuit television cameras were located in the bedroom and en suite areas in the seclusion suites. The viewing screens were located in the observation corridor outside. Staff told us the screens were switched on all the time therefore patients could be seen at all times. Patients did not have bathroom privacy. This was a blanket approach that was not individually risk assessed. Privacy and dignity were not being considered on an individualised basis. Acorn ward shared their seclusion suite with a female ward which meant potentially patient privacy and confidentiality could be compromised. Staff told us they would communicate with patients via the intercom and hatch therefore if both rooms were occupied at the same time, potentially patient confidentiality could be breached. In addition to this where patients had a history of trauma it may not be appropriate for patients of the opposite gender to be nursed in these areas. This potentially could cause further trauma to the patients.

We reviewed minutes from the provider's least restrictive practice group for July 2021, where it was acknowledged that "specialist training on Autistic Spectrum Disorders could help staff understand the impact of certain behaviours and language".

Local managers and senior leaders demonstrated a lack of compassion and understanding for their patients. We reviewed nurse manager meeting minutes and divisional governance meeting minutes and found the following examples of discriminatory and disrespectful attitudes; in reference to patient complaints on Meadow ward staff stated that the patient "will inevitably complain regularly"; "Some of the patients tend to deal with stress by producing complaints and this is part of their presentation, even if they are receiving the best possible care they will still complain so it is not an issue with the service, it is a patient characteristic and is being dealt with appropriately"; "There is an Autistic Spectrum Disorder patient who regularly makes complaints, this is due to their difficulties in communication, they will go to the complaints department first before talking to staff" and "Autistic Spectrum Disorder patients and part of their presentation is to make complaints".

Most staff were discreet and respectful when caring for patients. We observed staff treating patients with respect, kindness and dignity during the site visit.

Staff were responsive to patient needs.

Staff gave patients help, emotional support and advice when they needed it.

Staff did not always use appropriate communication methods to support patients to understand and manage their own care treatment or condition. Staff identified one patient's preferred communication method, however there were no staff trained to use this method.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved most patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that most patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved most patients in their care planning and risk assessments. However, three patients told us they were not given a copy of their care plan and three patients said they were not involved in their care plan.

On Meadow ward a patient requested to be fully involved in discussions about his care and treatment but had been told this was not possible and staff recorded "x refused to provide his requests due to wanting to be in the discussion". This patient's views were not included in his care plan and the section for family/carer involvement was also not completed despite his family being very involved. Another patient told us that they can put 'requests' in for discussion at ward round but are not allowed to be part of the discussion and are 'told' what they can have.

Inadequate

Wards for people with learning disabilities or autism

On Fern ward one patient told us they were not allowed to express their views and were told what to do.

Staff usually involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this.

We observed a community meeting on Meadow ward which was well attended by patients and staff. We reviewed further community meeting minutes which evidenced good involvement of patients.

On Acorn ward a patient told us their views are heard but it takes a long time for requests to be met.

However, we reviewed community meeting minutes for Marsh ward and there was no evidence of actions being taken in relation to concerns raised.

We reviewed 12 community meeting minutes from Brook ward between 1 April 2021 and 17 June 2021. We identified repeated issues being raised that were not resolved.

We reviewed an action plan dated May 2021 for actions agreed in the provider wide patient forum. We identified requests from patients that were not actioned for a number of months, including a query raised by a patient in January 2021 regarding a particular brand of vapes still not being responded to by May 2021. However, we saw evidence that meeting minutes and actions/initiatives were shared with nurse managers to involve patients who had not attended.

Staff made sure most patients could access advocacy services. However, on Marsh ward staff told us the advocate was only available via phone or video call.

Involvement of families and carers

Staff did not always inform and involved families and carers appropriately.

Staff did not always support, inform or involve families or carers. We spoke with six carers. Four of them (Acorn ward) expressed that communication from the service was poor describing it as “awful” and “non-existent”. One carer told us that staff were “indifferent”. One carer expressed frustration at trying to work with the service to support their relative and said they had “lost faith in them” (the service). We noted in clinical governance meeting minutes from January 2021 staff identified that the “family not happy with communication with the ward, ward are working on this.”

One carer told us staff do not inform them about incidents despite an Irish High Court order stipulating the family must be kept informed. One carer said they strongly dispute the provider’s claim on their website that they work alongside families and told us they have no involvement in care planning even though their son has consented to this.

However, the other two carers reported positive experiences of their loved one’s care on Brook and Acorn wards.

The provider reported “We also gain feedback through external peer reviews, Friends and Family Tests, Care Opinion and work closely with our PALS and Complaints team to support families and carers with any concerns or complaints they have.”

Are Wards for people with learning disabilities or autism responsive?

Inadequate

Wards for people with learning disabilities or autism

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Staff did not always plan and manage discharge well. As a result, patients sometimes experienced excessive lengths of stay. However, staff liaised well with services that would provide aftercare.

Bed management

The provider reported an average bed occupancy rate of 84% between July 2020 and June 2021.

Managers did not regularly review the length of stay for patients to ensure they did not stay longer than they needed to. The provider reported average length of stay data for six wards for July 2020 to June 2021 (no data for Meadow, Acorn and Fern as no discharges). Lower Harlestone (now Berry, Brook and Fern wards) reported the longest average length of stay at 3719 days. Marsh reported the shortest at 509 days.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. The provider reported five delayed discharges between July 2020 and June 2021 but no reasons for the delay were provided.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The service had not responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Patients could make hot drinks and snacks at any time. 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 variable quality.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff did not have access to a full range of rooms and equipment to support treatment and care.

The service had quiet areas and had access to a room where patients could meet with visitors in private.

The service had not responded to the needs of patients with autism in the ward environment. Patients on four wards (Meadow, Marsh, Fern and Acorn) did not have access to a sensory room and there was limited sensory equipment available on Hawkins ward. On Fern ward one patient told us they are sensitive to white lights and get headaches, they have had a headache every day since being admitted to the ward in September 2020, staff agreed to change to sensory lighting but this had not been done at the time of our visit.

Patients on the one of the low secure wards (Fern) were being cared for in a medium secure environment. Two patients told us they felt like they were in prison.

Patients could make phone calls in private.

The service had outside spaces that patients could access easily.

Patients could not always make their own hot or cold drinks and snacks. Staff on Hawkins ward closed the patient drinks area citing COVID as the reason why, despite other wards having their drink areas open. Patients on Hawkins ward and Sunley ward had to ask staff for a drink.

Some patients told us the service did not always offer a variety of good quality food. Two patients told us the food was of poor quality and another said it was ok.

Patients' engagement with the wider community

Staff supported most 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. Patients told us about their education and vocational opportunities. However, patients on the medium secure wards that recently moved to new premises reported a lack of access to facilities they previously used including light industry, arts and crafts and music.

Staff helped patients to stay in contact with families and carers. The provider reported supporting patients to stay in contact with family and friends through visits (restricted due to COVID), phone calls, video calls, written communication, care update meetings and carer events (pre COVID). The provider gave an example on Acorn ward "during the pandemic we had some imitation visits whereby a patient would get his food from Tompkins (on site café) and then spend the time on video call having his lunch as he normally would in Tompkins with his family to simulate the visit."

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of most 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. Staff devised communication plans for patients with communication needs. Staff used social stories and easy read versions of information to support patients.

Inadequate

Wards for people with learning disabilities or autism

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service could access information leaflets in multiple languages and formats to meet patients' communication needs.

Managers made sure staff and patients could get help from interpreters or 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 were not provided with food that met their cultural needs.

Most patients had access to spiritual, religious and cultural support. However, on Meadow ward one patient told us that their request to see an Imam more frequently had not been met. On Fern ward a patient had not been to the mosque for 26 months even though Ministry of Justice agreed to this.

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously, did not always investigate them and therefore did not learn lessons from the results that could be shared with the whole team and wider service.

Patients did not always know how to complain or raise concerns, however relatives and carers did.

The service clearly displayed information about how to raise a concern in patient areas.

Staff did not always understand the policy on complaints and know how to handle them and managers did not investigate all complaints. We reviewed divisional clinical governance meeting minutes for June 2021 which stated "One thing staff could try is to not raise the complaints straight away and wait a day or 2 and then ask the patient if they still want to make the complaint, this has been done on Hawkins and most of the time the patients would want to retract their complaints". We were concerned about the attitude to complaints evidenced by local managers and senior leaders in divisional governance meetings which minimised and dismissed complaints from patients with autism as being part of their condition.

On Marsh ward a patient told us no-one ever asked him if he knew how to complain. On Fern ward a patient told us they complained but staff advised an in issue had to be raised five times to be investigated.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

We requested information from the provider to include number of complaints and compliments received and number of complaints upheld, this was not provided.

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

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Inadequate

Wards for people with learning disabilities or autism

Leadership

Leaders did not always have a good understanding of the services they managed. Senior managers were not always visible in the service or approachable for patients and staff.

Not all staff and patients knew who the executive leaders were. Staff on three wards told us the executives did not visit and were not visible, staff on another three wards told us executives visit occasionally. However, we were also told that the deputy chief executive has completed shifts on two of the wards. Staff told us that the service (divisional) leaders were visible and approachable.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The hospital's leadership team successfully communicated the provider's vision and values to the frontline staff in this service.

Culture

Not all staff felt respected, supported and valued by managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.The service did not always provide opportunities for development and career progression. However, staff felt respected, supported and valued by the ward managers. staff felt they could raise any concerns without fear of retribution from the ward managers.

Across three wards (Marsh, Meadow and Fern) we asked six staff (including ward managers, clinical nurse leads, psychologists, social workers and healthcare assistants) to define a closed culture. Only one of the staff could describe what this was and how to assess the culture of their wards. Local leaders of Marsh and Meadow wards were not aware of the term 'closed cultures' despite the provider advising they conducted a closed culture review of the wards during late 2020 and early 2021 when they were Mackaness ward. We reviewed Meadow ward team meeting minutes for 30 June 2021. The minutes stated that "Staff are struggling to maintain boundaries and have appropriate therapeutic relationships with patients. The minutes also stated, "people are covering up other people's mistakes". Local leaders on Meadow ward told us staff did not have the confidence to speak up when something was wrong and there was still a culture of staff 'covering' for each other and not wanting to get colleagues in trouble.

Three staff reported feeling stressed and burnt out.

Not all staff felt respected, supported and valued by senior managers. However, staff told us they felt respected, supported and valued by ward managers.

Staff did not feel able to raise concerns without fear of retribution from senior managers but were confident to raise concerns at ward level.

Staff knew how to use the whistle-blowing process if they needed to.

Governance

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

Leaders failed to address all concerns identified in the last inspection in relation to staffing levels, patient risk assessments, observation practices and patient's access to leave.

Although senior managers ensured there were structures, processes and systems of accountability for the performance of the service, senior managers did not appear to support staff even when these systems showed consistently staffing was an issue across the wards. We viewed monthly governance minutes from April 2021 to June 2021 which stated there were staffing issues across all wards. The same concerns were discussed each month with no outcome or solution.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed at a ward and senior management team level meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. We identified discrepancies with staffing data on different systems. We reviewed minutes of divisional clinical governance meetings where ward managers raised issues that staffing data for their wards was inaccurate. Minutes from one meeting stated "Not getting an accurate picture of staffing in the mornings and evening due to the high amount of clock-ins having to be entered manually". The provider relied on data from their incident reporting system to provide an overview of acuity and concerns on wards, however, we identified that staff were not reporting all incidents on this system. We reviewed minutes from Hawkins ward clinical governance meeting in January 2021 where staff stated the dashboard recorded zero patients in seclusion when there had been three episodes of seclusion.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

Managers did not effectively manage ward performance despite using systems to identify, understand, monitor, and reduce or eliminate risks. We saw evidence in governance meeting minutes of these risks being escalated but we saw no evidence of an outcome to these.

We reviewed the risk register for the learning disability and autistic spectrum disorder division (includes female wards). The "Effects of CQC reports" was identified as a high risk with impact on reputation highlighted. "Increasing demand for enhanced support" was identified as a major risk with the impact of affecting the overall quality of patient care. Physical healthcare needs, restrictive practices and staff and patient safety were all rated as high risk.

Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Information management

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

Staff had access to the equipment and information technology needed to do their work.

Staff engaged in local and national quality improvement activities. Staff on Hawkins ward initiated continuous quality improvement projects including introducing mobile phones for patients, on ward computers, games for patients to play

and decorating the activity room. Hawkins ward won an internal award for their activity room. The provider advised there were nine continuous quality improvement projects in place across the learning disabilities and autistic spectrum disorder division (including female wards) using the plan, do, study, act approach. Staff had not fully completed the cycle for any projects.

The provider reported involvement in various research projects including: Collaboration with a university analysing the perceptions and feelings for service users and carers in terms of restrictive practices; Development of a Learning Disability Physical Activity Questionnaire; Application of the mental capacity act in Black and minority ethnic populations which has been presented in a conference with the academic department; Exploring seclusion and the experiences of women with learning disabilities within secure forensic services in the UK; Experience of Patient with Gender Identity Issues at two learning disability forensic wards; Social Information Processing in Offenders with Autism Spectrum Disorder; Should intellectual disability diagnoses be used in people with a history of developmental trauma; An exploration of staff perceptions and experiences of promoting physical activity among adult male learning disability and autistic spectrum disorder service users within a secure hospital setting.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

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

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Requires Improvement

Our rating of safe went down. We rated it as 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 thorough risk assessments of all ward areas and removed or reduced any risks they identified. For example, ensuring doorways into the garden were always clear. Staff could observe patients in all parts of the ward.

The ward complied with national guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients' safe. Closed circuit television cameras were in place throughout the ward, grounds and garden. The service had an up to date ligature risk assessment audit. The ward staff had access to body cameras to use in the patient bedroom areas, these could be worn to record any incidents with patients' consent. The recordings were reviewed as part of the multidisciplinary team meeting to manage risks, identify any new risks and inform any investigation work post incident.

Staff had easy access to Personal Infrared Transmitter (PIT) alarms and so could summon assistance as and when required. Staff tested alarms regularly. Patients had easy access to nurse call systems.

Staff followed policy and procedures in line with the current COVID-19 government guidelines. Staff checked and cleaned the emergency equipment and "I am clean" stickers were visible. There was adequate supply of hand sanitiser and masks where needed. One patient was in COVID-19 isolation at the time of this inspection. We observed staff donning and doffing masks, aprons and gloves appropriately.

Maintenance, cleanliness and infection control

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Ward areas were clean, well maintained, well furnished and fit for purpose. We saw a dedicated ward housekeeper working throughout the inspection.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records and the cleaning audit had an overall compliance of 95%.

Staff followed infection control policy, including handwashing. Infection Prevention and Control training was 100% compliant at the time of this inspection.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. There were no patients in the seclusion room at the time of this inspection. However, there was a strong, unpleasant odour in the seclusion room's en suite area.

We visited the extra-care suite on Heygate ward. At the time of our visit, the extra-care suite was occupied by a patient. Therefore, we were unable to check all aspects of the extra-care suite against the guidance in the Code of Practice.

Clinic room and equipment

The clinic room was large with plenty of space for clinical procedures, it was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. We saw up to date cleaning records in place.

Safe staffing

The ward was regularly short staffed because managers moved staff to other wards to cover shortfalls.

Nursing staff

Managers recruited enough staff with only one registered nurse vacancy and three health care assistant vacancies. The service had enough nursing and support staff to keep patients safe. The service had an establishment of ten registered nurses and 15 healthcare assistants. Levels of sickness were low.

Staff told us that the COVID-19 guidelines for testing impacted on staffing levels, as patients had to be quarantined until they received a negative test result. This meant that staff were having to do more observations on patients whilst in quarantine.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We saw during this inspection a bank member of staff being inducted to the ward at the beginning of a shift with a comprehensive handover of all patient risks.

The service had a low turnover rate of 10% in the 12 months leading up to this inspection.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of registered nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. However, staff told us that when they were fully staffed, staff would be moved to cover other wards staff shortages.

Patients did not always have regular one to one sessions with their named nurse, due to staff shortages.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The ward was supported by an occupational therapist to carry out therapeutic activities. Staff told us that leave was very rarely cancelled due to short staffing numbers.

The ward had enough staff on each shift to carry out any physical interventions safely. However, all staff we spoke to expressed concerns about the understaffing on other wards within the division.

Medical staff

Managers could call locums when they needed additional medical cover. The service had a locum Consultant and a locum Associate Specialist at the time of our inspection. Both doctors had been in post since March 2021. They told us the service had been unable to recruit to the advertised posts. They said they have enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up to date with their mandatory training which was comprehensive and met the needs of patients and staff.

The manager monitored mandatory training and alerted staff when they needed to update their training. The mandatory training rate on the ward was 97%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. The multidisciplinary team were all involved in completing patient risk assessments, so all aspects of care and treatment were considered. All care records for patients had up-to-date risk assessments and during ward rounds, staff discussed specific risks to each patient.

Management of patient risk

Staff undertook patient observations for long periods of time without a break. This impacted on staff well-being, morale and patient care. We saw evidence of one staff member on enhanced observations for over three hours without a break. Observations were not completed in line with policy and guidelines by the National Institute for Health and Care Excellence.

Staff did not always know about risks to patients. Staff did not get the time they required to read patients care plans or review updates to the patients risks. This meant that staff may not be aware of how to identify deterioration in a patient's mental health which could put patients and staff at risk of harm.

All patients had Personal Emergency Evacuation Plans (PEEPS).

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The ward displayed a list of contraband items and patients were aware of what was allowed on the ward.

Use of restrictive interventions

The service used rapid tranquilisation three times in the last month and monitored the patient's physical health in line with National Institute for Health and Care Excellence guidance. Staff successfully de-escalated patients and prevented the need for more restrictive interventions. Interventions were well documented, and restrictions had been reduced over time.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

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 knew how to make a safeguarding referral and who to inform if they had concerns. The ward had a safeguarding lead. Managers ensured staff compliance with safeguarding training. At the time of the inspection 100% of staff had received basic safeguarding training.

Staff said they felt confident to raise safeguarding issues with the senior management team. They knew when they should make referrals to the local authority and which safeguarding concerns to report direct to the regulator. They were aware of risks to children who were part of a patient's family or circle of friends and would act if concerns were raised about their safety as well.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

We looked at four patient records, they were electronic format and were comprehensive, and all staff could access them easily. They included up-to-date risk assessments, care plans for mental health and physical health, personal evacuation plans and COVID-19 information. Authorised staff, including bank and agency, could access patient notes.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. They followed current national practice to check patients had the correct medicines. Medicines records were complete and contained details on dose, when patients received them, and controlled drugs were double checked.

Staff regularly reviewed the effects of medicines on each patient's physical health. For example, blood testing, electrocardiogram (ECG) and following the use of rapid tranquilisation.

Staff stored and managed medicines and prescribing documents in line with the service's policy. There was an up-to-date stock list with all medicines in date and no excess stock. All medicines were stored safely in locked cupboards.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff reviewed the effects of each patient's medication on their physical health. The pharmacist gave advice and checked patients' medicines , particularly when their prescription changed. Patients and carers said they were encouraged to say when they experienced any problems with their medicines.

Decision making processes ensured that people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff knew which patients were prescribed medicines that could lead to addiction. They described how they monitored those patients and what they would do if they saw any signs a patient was becoming dependent.

Staff reviewed the effects of patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

The service had a variable track record on safety.

The provider reported 115 incidents for this service between 1 April 2021-30 June 2021. The most common incident type across all wards was 'Physical aggression and violence' accounting for 37 reported incidents.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers did not always share lessons learned from investigated incidents with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff managed patient safety incidents well, we saw a reduction in incidents in the six months leading up to this inspection. The nature of the incidents were fully recorded, along with the contributing factors and the actions staff needed to take to minimise the risk of reoccurrence.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Staff recognised incidents and reported them appropriately. The manager investigated incidents. However, there were no records to show that the manager shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff described what incidents to report and how to report them, incidents in the preceding 24 hours were also discussed at the morning management meeting.

Staff reported serious incidents clearly and in line with the providers policy.

Staff were able to describe their responsibilities in relation to duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

The manager debriefed and supported staff after any serious incidents.

The manager investigated incidents thoroughly. Patients and their families were involved in these investigations where appropriate.

Staff did not receive feedback from investigation of incidents via regular team meetings. No changes had been made as a result of feedback.

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

During this inspection the multidisciplinary team told us care plans were reviewed daily at the morning meeting.

We looked at four care records, all of which were personalised, holistic and recovery orientated. The notes were well written with a psychiatric intensive care unit crisis plan in place informing, supporting and educating those in crisis to develop strengths and strategies to reach identified goals.

Staff completed comprehensive physical health care check and a mental health assessment of each patient either on admission or soon after. This included an ECG, drug screening test, blood tests, blood pressure and temperature. The ward staff completed base line physical observations on all patients daily. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. However, we found that not all patients had a detailed pre- admission assessment form present in their care records.

Staff regularly reviewed and updated care plans when patients' needs changed.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

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.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff completed a 72 hour care plan on admission and within the first week the named nurse completed the keep connected, keeping safe, keeping well, keeping healthy and COVID-19 current restrictions care plans. Patients were offered a copy of their care plan and staff documented in the patient notes if this had been refused.

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation.

Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used health of the nation outcome scores to measure the health and social functioning of people with mental illness.

The service participated in clinical audit, benchmarking and quality improvement initiatives.

Staff identified patients' physical health needs and dietary needs which were recorded in their care plans. Patients had access to physical health care, including specialists as required, for example podiatry and dentist.

Skilled staff to deliver care

The ward team had access to the full range of specialists required to meet the needs of patients on the ward. 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 a full range of specialists to meet the needs of the patients on the ward.

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.

Managers made sure staff received any specialist training for their role. A health care assistant told us they had received training to undertaking ECG's and blood testing on patients.

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

Managers supported staff through regular, constructive appraisals of their work. Staff appraisal rates were 100% and clinical supervision rates were 100%.

Managers did not ensure staff attended regular team meetings or give information to those that could not attend. Staff were not updated on hospital governance and regional clinical governance, legal, ethical issues, relational security, environmental update, monitoring of clinical information, supervisions, appraisals, service user related issues, training, clinical risk management, therapeutic engagement, safe staffing, medication management, controlled drugs and service developments.

The manager recognised poor performance, could identify the reasons and dealt with these with support from the providers human resource team.

Multi-disciplinary and interagency teamwork

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 team 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.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with external teams and organisations, for example clinical commissioning groups and local authority safeguarding teams.

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 and discharged these well. 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. The provider reported 92% of permanent staff completed training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

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.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We looked at the Mental Health Act detention paperwork of two patients. The detention paperwork was complete and appeared to be in order. In both patients' paperwork, the MHA administrator had identified issues, during the scrutiny process, which they had raised with the approved mental health professionals.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The provider reported 92% of permanent staff completed training.

There was a clear policy on the Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

There were no Deprivation of Liberty Safeguards applications at the time of this inspection.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Good

Our rating of caring stayed the same. We rated it as 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.

We observed staff were discreet, respectful, and responsive when caring for patients. They provided help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their 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.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, easy read versions of information leaflets.

Staff involved patients in decisions about the service, when appropriate. Patients made suggestions on therapeutic activities.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. The ward staff had access language interpreting services.

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this during the community meeting, the service displayed a “you said” “we did” board in the lounge area, which clearly demonstrated changes had been made based on feedback.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients had access to advocacy services.

Involvement of families and carers

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. The two carers we spoke with gave positive feedback about the staff. They said they felt well informed and could always talk to a staff member on the telephone.

Are Acute wards for adults of working age and psychiatric intensive care units responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. At the time of inspection there were six patients admitted to the ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. At the time of inspection one patient was being discharged back to home area after a five day stay. Managers and staff worked to make sure they did not discharge patients before they were ready.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had one delayed discharge due to appropriate placement needs, in the past year.

Managers monitored the number of delayed discharges. The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. 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.

Each patient had their own bedroom, which they could personalise based on risk assessment.

Patients had a secure place to store personal possessions in their bedrooms. Any contraband items were stored in a separate locker.

Staff used a full range of rooms and equipment to support treatment and care. The ward had several rooms to use for one to one time with patients, including a sensory room, a multi faith room and a de-escalation suite.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private.

The service had an outside space that patients could access easily, with access to raised garden beds for the patient's therapeutic activities.

Patients could make their own hot drinks in the day room and snacks and were not dependent on staff.

The service offered a variety of good quality healthy food, snacks were available, and patients could access these when required.

Patients' engagement with the wider community

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

Staff helped patients to stay in contact with families and carers. Patients had access to technology to enable them to keep in touch with family virtually. All patients had use of their own mobile phones. Staff supported the patients to charge their phones.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients regularly used the shops in the hospital grounds, the gym and walked around the hospital grounds. Staff told us the ward participated in a walking challenge around the hospital grounds with patients.

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. All patients had a personal emergency evacuation plan in place.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Posters were displayed throughout the ward.

The service had information leaflets available in languages spoken by the patients and local community. One patient told us they had their rights read to them in their spoken language with the help from translation services.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. One patient told us the food was excellent with plenty of healthy options.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Patients had access to spiritual, religious and cultural support and a multi faith room was available.

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.

We saw evidence of a recent complaint that the manager dealt with at local level with positive resolution. There had been no formal complaints in the last 12 months.

The service clearly displayed information in patient areas about how to raise a concern. Patients, relatives and carers we spoke to knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they manage. However, the leadership, governance and culture of the ward did not always support the delivery of high-quality person-centred care.

Improvements were not always identified or shared within the team. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance or monitored.

We saw that staff satisfaction was mixed, one member of staff told us that improving staff satisfaction is not seen as a high priority. Staff did not always feel actively engaged or empowered. All staff we spoke with expressed concerns about the understaffing on other wards within the division. They told us that when they were fully staffed, managers moved staff to cover shortages of staff on other wards.

Leaders were not always aware of the risks, issues and challenges in the service as this information was not shared within the ward team meeting.

Vision and strategy

Staff did not fully understand the provider's vision and values and how they applied to the work of their team.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

The ward displayed the organisational strategy, “relieve suffering, give hope and promote recovery”. The ward offered an evidence based clinical model that introduced a number of interventions that increase safety and improves relations between staff and patients, resulting in fewer assaults on staff. However, staff told us they were not fully informed at team meetings about the running of the hospital, risks and staffing. This impacted on staff morale and then patient care as a result. Staff did not fully understand how their role contributed to achieving the strategy.

We saw that progress against delivery of the strategy and plans was not effectively monitored or reviewed and there was no evidence of progress.

Culture

Staff did not feel respected, supported and valued. However, they said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff did not always raise concerns as they felt they were not always taken seriously, appropriately supported, or treated with respect when they did.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider had a care awards initiative to celebrate success and improve the quality of care across the organisations four core values, accountability, compassion, respect and excellence. This award was presented monthly to nominated staff across the division.

Governance

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

The arrangements for governance and performance management did not always operate effectively.

Managers advised that clinical audits were undertaken mainly by staff external to the wards. These included medication, infection control, clinical notes and case tracking. The staff we spoke with did not know the outcomes or action plans from audits, they did not know how this affected patient care and what improvements could be made.

However, managers had oversight to ensure mandatory training, appraisals and supervisions were completed. Managers ensured that staff were aware of the service COVID-19 testing arrangements. We were told COVID-19 risk assessments were in place, and posters were displayed in staff areas.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care.

The manager maintained and had access to the risk register and staff could escalate concerns in the daily meeting for adding to the risk register.

The service had plans for emergencies. For example, COVID-19 pandemic, fire plans and health emergencies.

Information management

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 population.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

The manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used.

Patients and carers had opportunities to give feedback on the service via feedback forms to reflect their individual needs.

The ward had a folder with compliments, thank you cards and complaints available for all staff to review. The manager ensured that feedback from patients was listened to and acted on.

Patients were involved in decision making about changes to the service.

Directorate leaders engaged with external stakeholders, such as commissioners and independent champions for health and social care.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints On the wards for people with a learning disability or autism senior managers and staff were sometimes dismissive of complaints from patients with autism.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care On the long stay rehabilitation wards staff had not completed discharge plans for all patients. Patients were not always aware of their specific goals for discharge. On the wards for people with a learning disability or autism the service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Staff did not always support, inform and involve families or carers. Patients regularly had their therapies or activities cancelled or cut short.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment On the forensic wards staff had not recognised or reported one safeguarding incident and we were not assured staff

This section is primarily information for the provider

Requirement notices

knew when to escalate incidents such as financial issues. Staff secluded another patient for longer than necessary, recording that the patient had been “relatively stable for the past two weeks whilst in seclusion”.

On the long stay rehabilitation wards the providers compliance with safeguarding level three training on two of the three wards was low at 60% and 63%.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Across all core services the providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. At the psychiatric intensive care unit the manager did not share lessons learned with the whole team when things went wrong. Improvements were not always identified or shared within the team. The leadership, governance and culture for the ward did not always support the delivery of high-quality person-centred care. Staff did not always raise concerns as they felt they were not always taken seriously, appropriately supported, or treated with respect when they did. Not all leaders had the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Staff did not understand how their role contributed to achieving the service strategy. Staff did not always feel respected, supported or valued. On the forensic wards managers did not ensure staff kept accurate records. Senior leaders were not always visible on the wards. Two managers told us they did not feel supported by senior leaders on matters such as staffing levels and recording supervision. These managers told us they felt senior managers did not fully appreciate the pressures faced by staff on the wards and their focus was on different priorities for the service. Governance systems and processes were not always robust. We were not assured managers would recognise and identify all potential risk issues.

This section is primarily information for the provider

Requirement notices

On the wards for people with learning disabilities or autism leadership and governance arrangements had not addressed previous issues or ensured concerns were identified and acted on. Leaders did not always have a good understanding of the services they managed. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers.

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 On the psychiatric intensive care unit staff undertook patient observations for long periods of time without a break. This impacted on staff well-being, morale and patient care. Observations were not completed in line with policy and guidelines by the National Institute for Health and Care Excellence. We were not assured staff knew the individual risks for patients which meant they might not be able to identify a deterioration in patients mental health, which may put staff and patients at risk. On the forensic wards staff were not always completing patient's observation records accurately and staff did not always receive breaks between observing patients. Only 54% of registered nurses completed immediate life support training. This posed a risk to patients who require immediate medical attention. Across the service five out twelve nurse call alarms were either not working or damaged. Five of eighteen care plans we reviewed were incomplete and staff had not followed up on the progress notes. Staff had not followed physical healthcare plans of two patients. Seclusion rooms on all wards met most but not all guidance in the Mental Health Act Code of Practice. There was no exit plan for a patient in long term segregation on one of the wards. Staff did not always keep clear records or follow best practice guidelines when patients were in long term segregation or seclusion. On the long stay rehabilitation wards clinic rooms were not adequately equipped to meet patient need. Two of the three wards did not have access to emergency

This section is primarily information for the provider

Requirement notices

resuscitation equipment on the ward. All three wards did not have oxygen signs on the clinic room door. The seclusion rooms consisted of blind spots that the staff were not aware of. This increased the risk of patients harming themselves when using the facilities. We found blind spots in the garden that the staff were not aware of. Staff did not always learn lessons from incidents and follow processes put into place after incidents.

On the wards for people with a learning disability or autism staff did not always ensure patients' physical healthcare needs were met. Staff were not always following systems and processes when administering, recording and storing medicines. Not all ward areas were safe, clean and well maintained. Seclusion rooms did not meet all of the guidance in the Mental Health Act Code of Practice. When a patient was placed in seclusion or long term segregation staff did not always follow best practice guidelines in the Mental Health Act Code of Practice. Managers had not ensured all staff completed mandatory training.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The psychiatric intensive care unit was regularly short staffed because managers moved staff to other wards to cover shortfalls. The forensic wards did not have enough nursing or support staff to keep patients safe and ensure all patients care needs were met all the time. On the long stay rehabilitation wards managers allocated therapy staff to frontline shift work due to staffing shortages which impacted on the delivery of therapies to patients. Patients leave was affected by and planned around staffing levels and not around patient choice. We found therapy sessions had been cut short or cancelled due to staffing levels.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

On the forensic inpatient/secure wards staff did not always protect the privacy and dignity of a patient in seclusion.

On the wards for people with a learning disability or autism senior managers and staff did not always treat patients with compassion and kindness.

This section is primarily information for the provider

Enforcement actions

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 On the wards for people with learning disabilities or autism staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always know what incidents to report and how to report them.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The wards for people with learning disabilities and autism did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients regularly had their escorted leave, therapies or activities cancelled or cut short, due to staffing shortages.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment On the wards for people with a learning disability or autism staff were unable to define a closed culture. Staff kept a patient in seclusion for longer than required.

St Andrew's Healthcare

St Andrew's Healthcare - Womens Service

Inspection report

Billing Road
Northampton
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Date of inspection visit: 5-8, 20-21, 29 July 2021 and 3-5 August 2021
Date of publication: N/A (DRAFT)

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

This service was placed in special measures on 10 June 2020. Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall. Therefore, we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Edward Baker
Chief Inspector of Hospitals

Our rating of this location stayed the same. We rated it as inadequate because:

Following our inspection we took urgent action because of immediate concerns we had about the safety of patients on the forensic, long stay rehabilitation and learning disability and autism wards. Conditions were placed on the provider's registration that included the following requirements; that the provider must not admit any new patients without permission from the CQC; that wards must be staffed with the required numbers of suitably skilled staff to meet patients' needs; that staff undertaking patient observations must do so in line with the provider's policy; that staff must receive required training for their role and that audits of incident reporting are completed. The provider is required to provide CQC with an update relating to these issues on a fortnightly basis.

- Staff on the forensic, long stay rehabilitation and learning disability and autism wards did not always treat patients with compassion and kindness. Staff did not always respect patients' privacy and dignity on the forensic and long stay rehabilitation wards. Staff at the learning disability and autism wards were unable to define a closed culture or describe how they ensured patients were protected from the risks associated with a closed culture developing.
- The service did not have enough nursing and support staff to keep patients safe at all core services. Patients regularly had their escorted leave, therapies or activities cancelled because of staff shortages.
- Staff did not manage risks to patients and themselves well. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others at all core services. Staff on long stay rehabilitation wards did not always know what incidents to report and how to report them, however staff in the other services we inspected did know what to report and how. Staff did not always follow the Mental Health Act code of practice in relation to seclusion, long term segregation, blanket restrictions and section 17 leave on the long stay rehabilitation and learning disability and autism wards. Staff were not always updating patient risk assessments and care plans at the psychiatric intensive care and long stay rehabilitation wards. Staff did not always ensure patients' physical healthcare needs were met at the psychiatric intensive care, forensic and long stay rehabilitation wards. Not all ward areas at the long stay rehabilitation service and learning disability and autism service were safe, clean and well maintained. Staff on the forensic wards did not always follow infection control procedures.
- Managers did not ensure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care on the forensic wards and learning disability and autism wards. The provider had not fully responded to the needs of patients on the long stay rehabilitation and learning disability and autism wards.

Summary of findings

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. Leaders at the long stay rehabilitation services did not have the skills, knowledge and experience to perform their roles. Concerns identified at previous inspections had not always been addressed.
- Staff did not always feel respected, supported and valued on the long stay rehabilitation and learning disability and autism wards. Managers did not always support staff with appraisals, supervision and opportunities to update and further develop their skills on the forensic and long stay rehabilitation wards.

However:

- Each patient had their own en suite bedroom, which they could personalise.
- Leadership development opportunities were available.
- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Capacity Act.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	Our rating of this service stayed the same. We rated it as requires improvement because: • The service did not have enough nursing and support staff to keep patients safe. Staffing levels on the ward meant that staff were regularly completing patient enhanced observations for longer than five hours at a time. This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence. • Staff did not review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Two patients who were prescribed high dosage anti-psychotics did not have a care plan in place to monitor the effects on their physical health. • Our findings from the other key questions demonstrated that performance and risk were not managed well. The provider's data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. Managers had not addressed staff allocation to patient observations for long periods or reliance on multi disciplinary staff to cover breaks. However: • The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. • Staff completed and kept up to date with mandatory training. • Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. • Staff made sure patients had access to physical health care, including specialists as required.

Summary of findings

- Patients and carers told us that staff were caring, respectful and polite. Staff kept family members informed and involved in patients' care.

We rated this service as requires improvement because it was not safe or well led.

Forensic inpatient or secure wards

Inadequate

Our rating of this service stayed the same. We rated it as inadequate because:

- Staff were not always able to protect patients' dignity. Staff were unable to meet a patient's needs on Bracken ward which resulted in them being unable to get to the toilet in time.
- The service did not have enough nursing and support staff to keep patients safe. On Willow ward we found recorded evidence of incidents where patient observations had been missed and night staff had to remain on shift due to a lack of day staff. We reviewed an incident on Bracken ward whereby a patient was able to tie a ligature due to the day area being left unobserved.
- Staff did not always follow infection control procedures. Four staff on Willow ward were observed to be wearing masks incorrectly. This was reported to managers as we were concerned that Personal Protective Equipment was not being used effectively.
- Staff did not always meet patients' dietary needs, and correctly assess patients who had specialist care needs for nutrition and hydration. We reviewed an incident on Willow ward that occurred in May 2021 where staff did not respond effectively when a patient refused food and then fluids. This resulted in the patient being admitted to the acute hospital for rehydration. The acute hospital raised this concern as a safeguarding for investigation.
- Managers did not ensure that staff had the right skills and experience to meet the needs of the patients. New and inexperienced staff were being sent to Bracken ward to provide cover due to staff shortages. We observed this on 8 July 2021 and observed that staff had insufficient time to give new covering staff a

Summary of findings

handover. Staff did not always appear to understand the individual needs of patients or support patients to understand and manage their care treatment or condition.

- On Bracken ward patients could not make hot drinks and snacks independently of staff. All drinks were kept in the office and patients had to ask staff to make them. If the ward was short staffed this could result in a delay to patients receiving a drink.
- Leaders had not addressed some of the concerns raised at previous inspections such as low staffing levels and patient observations.

However:

- Wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.
- Care plans were personalised, holistic, and recovery orientated, and patients were routinely offered a copy of their care plan.
- Carers gave positive feedback about the staff.
- Each patient had their own en suite bedroom, which they could personalise. We saw examples of this during the inspection where patients had their own duvet covers, photographs, posters and music collections.
- Leadership development opportunities were available.

We rated this service as inadequate because it was not safe, effective, caring or well led.

Wards for people with learning disabilities or autism

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- The service did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Senior leaders did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Patients regularly had their escorted

Summary of findings

leave, or activities cancelled, due to the ward being short staffed. Staff did not always provide a range of care and treatment suitable for the patients in the service.

- Staff did not always manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy.
- Staff did not always treat patients with compassion and kindness. They did not actively involve families and carers in care decisions.
- The service had not fully responded to the needs of patients with autism in the ward environment. Patients were not protected from closed cultures. Staff had not completed specialist training to meet the needs of patients. The design, layout, and furnishings of the ward did not always support patients' treatment. Wards had blanket restrictions in place. Not all patients could make hot drinks and snacks at any time.
- Senior managers did not always have a good understanding of the services they managed. Senior managers were not always visible in the service or approachable for patients and staff. Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level.
- Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice. When a patient was placed in seclusion, staff did not always follow best practice guidelines.

Summary of findings

When a patient was placed in long term-segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice.

However:

- The ward environments were clean.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Ward leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Our rating of this location went down. We rated it as inadequate because:

- Staff did not always treat patients with compassion and kindness. They did not respect patients' privacy and dignity. Staff did not intervene to support patients when harming themselves or in distress. Staff did not ensure patients access to the toilet at all times.
- The service did not have enough nursing and support staff to keep patients safe and the wards were regularly short staffed. Patients and staff told us on escorted leave and activities were cancelled due to the service being short staffed. The service did not always have enough staff on each shift to carry out physical interventions safely.
- Staff did not always manage risks to patients and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour and levels of

Summary of findings

restrictive interventions were high. Staff did not always know about risks to each patient, staff did not always act to prevent or reduce risks. Risk assessments were not updated after each incident. Staff did not always follow the Mental Health Act code of practice in relation to seclusion, long term segregation and blanket restrictions.

- Wards were not always safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff did not always complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified. Patients and carers told us there has frequently been issues with toilets blocking, shower heads spraying and light bulbs in bedrooms needing replacing.
- The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.
- Staff did not always assess the physical health of all patients on admission or support patients with their physical health. Staff failed to carry out recommended physical health observations following episodes of patients' head banging and administration of rapid tranquillisation medicine.
- Staff did not always inform and involve families and carers appropriately. Staff support, information and involvement for families or carers was inconsistent.
- The service did not meet the needs of all patients – including those with a protected characteristic. The service could not always support and make adjustments for disabled people. Staff had not made reasonable adjustments to ensure wheelchair bound patients could evacuate in an emergency.
- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on risk

Summary of findings

management and incident management and reporting. Teams did not always have access to the information they needed to provide safe and effective care.

- Staff did not always feel respected, supported and valued. Staff told us they felt burnt out, stressed and unsupported. Managers did not always support staff who needed time off for ill health. Managers did not always support staff with appraisals, supervision and opportunities to update and further develop their skills.

However:

- Staff introduced patients to the ward and the services as part of their admission. Staff made sure patients understood their care and treatment. Patients could give feedback on the service and their treatment and staff supported them to do this.
- Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff always regularly reviewed the effects of medications on each patient's mental and physical health.
- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Capacity Act.

We rated this service as inadequate because it was not safe, effective, caring, responsive or well led.

Summary of findings

Contents

Summary of this inspection

Background to St Andrew's Healthcare - Womens Service

St Andrew's Healthcare Women's location has been registered with the CQC since 11 April 2011. The service has a registered manager and a controlled drugs accountable officer.

This location consists of four core services: acute wards for adults of working age and psychiatric intensive care units; long stay/rehabilitation mental health wards for working age adults; forensic/inpatient secure wards; wards for people with learning disabilities or autism.

St Andrew's Healthcare Women's location is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

This location has been inspected nine times. The most recent inspection in July 2020 was a focused inspection of one ward, Spencer South (now Upper Harlestone ward). We took enforcement action for breaches of the following regulation:

- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We issued requirement notices for breaches of the following regulations:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment.
- Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

The last comprehensive inspection of this location was in March 2020. The location was rated as inadequate overall; inadequate for safe, requires improvement for effective, inadequate for caring, good for responsive and requires improvement for well led. We took enforcement action for breaches of the following regulations:

- Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and Respect.
- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.
- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We issued requirement notices for breaches of the following regulations:

- Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

We found that the provider addressed some, but not all of the issues from the last inspection. The issues that remain are identified later in this report.

The following services and wards were visited on this inspection:

Acute wards for adults of working age and psychiatric intensive care units:

- Bayley ward, a psychiatric intensive care unit with 10 beds.

Summary of this inspection

Forensic inpatient/secure wards:

- Bracken ward, a medium secure ward with 10 beds.
- Willow ward, a blended low/medium secure ward with 10 beds.
- Maple ward, a blended low/medium secure ward with 10 beds.

Long stay / rehabilitation wards for working age adults:

- Upper Harlestone ward (previously Spencer South ward) with 12 beds.
- Ashby ward (previously Spring Hill House) with 16 beds.
- Naseby ward (previously Hereward Wake ward) with 15 beds.

Wards for people with learning disabilities or autism:

- Oak ward, a 10 bed medium secure service for women with learning disabilities and/or autistic spectrum conditions.
- Church ward, a 10 bed low secure service for women with learning disabilities and/or autistic spectrum conditions.
- Sycamore ward, a 4 bed medium secure enhanced support service for women with learning disabilities and/or autistic spectrum conditions.

What people who use the service say

We spoke with 28 patients.

At the psychiatric intensive care unit we spoke with two patients who told us that the ward was clean and safe. They told us that the ward was understaffed but that staff were caring, kind and respectful.

At the forensic inpatient/secure wards we spoke with seven patients. Six out of the seven patients said that there were never enough staff on the wards. Patients said the impact of this was that they often had their leave cancelled, even though they had been encouraged by the multi-disciplinary team to utilise their leave as much as possible. Three out of seven patients said that activities were often cancelled due to lack of staff and two patients told us that dialectical behavioural therapy (DBT) had recently been cancelled twice. Three patients told us that there was not enough to do on the wards due to activities being cancelled. This impacted on their wellbeing as they were bored and left with too much time to think.

One patient said that there were too many incidents of self-harm and three out of seven patients said that the wards felt unsafe. Two patients noticed that the alarms did not always work. Community meetings were held regularly and whilst patients attended, they said that they were repetitive and that nothing much got done. One patient raised concerns about low staffing levels, but nothing changed.

Two patients were unhappy about the food and said that there was a lack of variety and that pasta dishes were served too frequently. One said that they thought they were still on the winter menu when it should have been changed to the summer menu.

Generally, patients told us that staff were nice, but they often saw staff that they were unfamiliar with on the wards.

At the long stay / rehabilitation wards we spoke with nine patients who told us there are not enough staff on shift, activities and leave are cancelled, and it can feel dangerous.

Summary of this inspection

At the wards for people with learning disabilities or autism we spoke with 11 patients. Four patients told us the wards were short staffed. Two patients told us they had their escorted leave or activities cancelled due to the wards being short staffed, only one of these patients told us this was then rearranged.

One patient said there was not a lot to do on the ward.

Two patients told us they get feedback from incident investigations. Two patients told us they did not always get updates from their complaints.

Two patients told us they were not given a copy of their care plan and one patient said they would like a copy.

Three patients on Church ward told us night staff were rude. One patient on Church ward told us that she had sworn at staff and they had sworn back at her. One patient on Church ward told us that night staff ignore them.

One patient on Church ward told us that night staff sometimes come in chewing gum. Two patients on Church ward told us that night staff bring their mobile phones onto the ward and use them. Mobile phones and chewing gum are contraband items on the wards.

Two patients on Oak ward told us night staff denied them a drink during the night. One patient told us she had been denied a drink because night staff were asleep. One patient told us on Church ward and two patients on Oak ward told us that night staff fall asleep on night shifts whilst doing their enhanced observations.

We spoke with 27 carers.

At the psychiatric intensive care unit we spoke with three carers who all felt that they were kept up to date and received regular phone calls from ward staff.

At the forensic inpatient/secure wards we spoke with six carers. Three carers said that they had close communication with the hospital and that they had been asked to provide feedback about the service. Three carers (50%) felt that they were kept involved in their relative's care and treatment and that they were regularly provided with information and invited to meetings.

Four out of six carers spoke positively about the staff and only one carer was aware of cancelled leave.

At the long stay / rehabilitation wards we spoke with 14 carers. Carers told us that contact from staff was erratic, sometimes they would receive several calls a week and then not have contact for extended periods of time. A carer told us that "staff won't try and de-escalate; they do not explore the least restrictive option and go straight to restraint" and that the system feels punitive rather than encouraging and rewarding.

At the wards for people with learning disabilities or autism we spoke with four carers. One carer told us there had been times when patient section 17 leave hasn't been supported due to staff shortage or the patient had an incident and their leave was cancelled. One carer told us not all staff treat their relative with respect. Two carers told us they had not been invited to attend any of their relative's meetings. Three carers told us they never received any information about a carer's assessment.

Summary of this inspection

How we carried out this inspection

The inspection team visited services and wards between 6 July and 8 July 2021 on 20 and 21 July 2021 and completed further off-site inspection activity until 5 August 2021. During the inspection we:

- Visited the service and observed how staff cared for patients
- Toured the clinical environments
- Looked at the medicine management on the wards
- Spoke with 27 patients that were using the service
- Interviewed 55 staff and managers, including ward managers, clinical leads, doctors, nurses, healthcare assistants, psychologists, occupational therapists, technical instructors, social workers, dieticians, pharmacists, students and volunteers.
- Interviewed eight senior managers and the provider's quality improvement lead
- Spoke with 27 carers
- Observed two community meetings and two team meetings
- Observed three episodes of care
- Reviewed 47 patient care records
- Reviewed policies and procedures relevant to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Acute wards for adults of working age and psychiatric intensive care units core service:

- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff review the effects of patients' medicines on their physical health. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Forensic inpatient/secure wards core service:

- The provider must ensure staff are able to respect patients' dignity at all times. (Regulation 10 (1))

Summary of this inspection

- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion and blanket restrictions. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff provide required physical health interventions in a timely manner. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Long stay / rehabilitation wards for working age adults core service:

- The provider must ensure staff treat patients with kindness, respect and dignity. (Regulation 10 (1))
- The provider must review the use of restrictive interventions on the wards and take action to reduce these. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff report and record all incidents appropriately. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff meet patient's physical healthcare needs. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure all staff are aware of and follow patient care and risk management plans. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff review and update individual risk assessments and care plans for all patients. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that the environment is well maintained, safe, clean and fit for purpose. (Regulation 12 (1) (2) (a) (b) (d))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and blanket restrictions. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))

Wards for people with learning disabilities or autism core service:

- The provider must ensure the service provides a range of care and treatment suitable for the patients in the service. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure the wards respond to the needs of patients with autism in the ward environment. (Regulation 9 (1) (a) (b) (c))
- The provider must ensure staff treat patients with kindness, respect and dignity at all times, including use of appropriate language. (Regulation 10 (1))
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation, blanket restrictions and section 17 leave. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure long term segregation environments meet the Mental Health Act Code of Practice. (Regulation 12 (1) (2) (d))
- The provider must ensure all staff are aware of what constitutes a closed culture. (Regulation 13 (1) (2))
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))

Summary of this inspection

- The provider must ensure their data is accurate. (Regulation 17 (1) (2) (d))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))
- The provider must ensure that staff receive the required specialist training to carry out their roles effectively. (Regulation 18 (2) (a))

Action the service SHOULD take to improve:

Acute wards for adults of working age and psychiatric intensive care units core service:

- The provider should ensure staff complete specialist care plans for all patients as required. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure they provide patients with a copy of their care plan. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure they provide outcomes to issues raised by staff (Regulation 17 (1) (2) (e) (f))

Long stay / rehabilitation wards for working age adults core service:

- The provider should ensure staff inform and involve families and carers appropriately. (Regulation 9 (1) (3) (f))
- The provider should ensure staff have access to regular team meetings. (Regulation 18 (2) (a))
- The provider should ensure staff receive regular supervision, appraisal and opportunities to learn. (Regulation 18 (2) (a))
- The provider should ensure staff are supported and able to access support functions when required. (Regulation 18 (2) (a))

Wards for people with learning disabilities or autism core service:

- The provider should ensure seclusion rooms have a fixed table for patients to use. (Regulation 12 (1) (2) (d))
- The provider should ensure when paperwork is updated electronically it is printed if these are the copies staff are relying on to support patients safely and effectively. (Regulation 17 (1) (2) (c))
- The provider should ensure staff review care plans when required. (Regulation 17 (1) (2) (c))
- The provider should ensure patient's Mental Health Act detention paperwork is clear. (Regulation 17 (1) (2) (c))
- The provider should ensure staff inform and involve families and carers appropriately. (Regulation 9 (1) (3) (f))
- The provider should ensure they regularly review the length of stay for patients to ensure they did not stay longer than needed. (Regulation 9 (1) (a) (b) (c))
- The provider should ensure senior managers have a good understanding of the services they manage and be visible in the service and approachable for patients and staff. (Regulation 17 (1) (2) (f))
- The provider should ensure that staff feel able to raise any concerns without fear of retribution from senior managers. (Regulation 17 (1) (2) (f))
- The provider should ensure they provide outcomes to issues raised in governance meetings. (Regulation 17 (1) (2) (e) (f))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Requires Improvement	Good	Inadequate	Inadequate
Wards for people with learning disabilities or autism	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

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

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Requires Improvement

Our rating of safe improved. We rated it as 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 thorough risk assessments of all ward areas and removed or reduced any risks they identified. The environmental risk assessment had been updated in February 2021.

Staff could observe patients in all parts of the wards.

The ward complied with guidance and there was no mixed sex accommodation as it only accommodates female patients.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Patient bedrooms and bathrooms were furnished with anti-ligature fittings and staff were aware of potential ligature anchor points in communal areas. The ward had ligature cutters available to staff in key areas of the ward to allow quick access in the event of a ligature incident.

Staff had easy access to alarms, and all carried personal alarms to call for assistance. Patients did not have call systems in bedrooms however there were staff based in the bedroom corridors if patients required assistance.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. The ward had housekeeping staff complete cleaning on most days however there had been some gaps where nursing staff had to complete the ward cleaning. All ward areas were visibly clean and no concerns were raised by patients about cleanliness.

Staff followed infection control policy, including handwashing. Staff wore masks at all times and additional personal protective equipment when required. Staff washed their hands on entry to the ward and throughout shifts and sanitising hand gel was available on the ward.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked clinic rooms weekly and kept records of findings, and the ward pharmacist audited controlled drugs.

Staff checked, maintained, and cleaned equipment. Staff recorded calibration and cleaning of equipment, and used clean stickers when this was completed.

Safe staffing

The service did not have enough nursing or support staff. However, staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. The service did not have enough staff on each shift to carry out any physical interventions safely.

Although vacancy rates were low with one qualified nurse vacancy and no healthcare assistant vacancies the service used a model to plan staffing of shifts that did not fully consider the number of observations required on the ward. The service used 'planned numbers' and 'optimum numbers' when planning shift staffing. Staff reported that it was rare for a shift to be staffed at optimum numbers and when a shift did have the optimum number of staff, nursing staff would be moved to another ward to meet their planned number of staff.

The planned staffing levels required staff to be allocated to observations of patients on enhanced observations for longer periods than prescribed. Staff shift rotas and observation records showed that between 25 May and 2 July 2021 staff had been allocated to patient observations for longer than five hours without a break on ten occasions. Between 25 May and 2 July 2021 staff had been allocated to patient observations for over eight hours without a break on two occasions. Multi disciplinary staff were regularly used to complete observations during nursing staff breaks.

This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence. Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

Staff reported that sometimes they did not feel safe on the ward due to the staffing levels.

The ward manager could adjust staffing levels according to the needs of the patients but only within the staffing model designated by the provider.

Managers limited their use of bank staff and requested staff familiar with the service. Bank staff were allocated by directorate so that they would be familiar with the needs of the patient group. Bank staff were given an induction onto the ward and attended handover meetings at the start of their shift to familiarise them with the patients.

The service had low turnover rates. The ward reported no staff turnover in the three months prior to inspection.

Levels of sickness were low with 7% staff sickness in the three months prior to inspection.

Patients had regular one to one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The ward manager and multi disciplinary staff were sometimes required to escort patients for activities or leave off the ward in order to maintain staffing levels on the ward.

Staff shared key information to keep patients safe when handing over their care to others. Staff attended a handover meeting at the start of morning and evening shifts where patients and ward activities were discussed.

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. The ward had a locum consultant psychiatrist and associate specialist doctor in post who covered across the men's and women's ward. The provider had out of hours cover available for evenings and weekends.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. Staff compliance with mandatory training sessions was 98%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training sessions included Safeguarding Adults and Children, Immediate life Support, Least Restrictive Practice, and Infection Control.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers used an electronic dashboard system to monitor staff compliance with training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed five risk assessments and found that they were all thorough and had been updated regularly including after any incidents.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff completed a crisis plan for all patients on the ward following their risk assessment to help mitigate against risks.

Staff could observe patients in all areas of the ward.

Staff followed provider policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. The ward reported 88 incidents involving restraint in the three months prior to inspection, with two of those involving prone restraint when the patient moved into a prone position before staff moved them into a supine position. The ward reported 16 instances of rapid tranquilisation and 16 instances of seclusion. The ward did not report any incidents of long term segregation.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

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.

Staff on the ward were piloting the use of wearing body cameras that would be switched on before a patient restraint and felt that this contributed to a reduction in incidents leading to restraint.

Staff understood the Mental Capacity Act definition of restraint and worked within it. All staff were up to date with training in the Mental Capacity Act.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. We reviewed the seclusion paperwork of two patients (two episodes of seclusion for one patient and one episode for the second patient). We found the paperwork met some, but not all of the guidance in the Code of Practice. For example, in two records we were unable to find any evidence of the patient's family member being informed of the patient's seclusion. In another record, there was no evidence of an independent multidisciplinary team review taking place after the patient's eight hours of consecutive seclusion.

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 kept up-to-date with their safeguarding training and 100% of staff completed either level 2 or level 3 safeguarding of adults and children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The ward social worker was the contact point for any safeguarding concerns and reviewed any incidents logged as a safeguarding. The social worker liaised with the hospital safeguarding lead and the local authority to explore any issues and whether the concern met the threshold for local authority investigation.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily.

The service used an electronic patient record system that was easy to access. Staff recorded patient observation notes on paper records and these were then uploaded onto the electronic system. Staff completing patient care plans had to print the forms off to complete with the patient and then type the notes up on the electronic system.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

Staff did not always review the effects of medicines on each patient's mental and physical health. However, the service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff did not record patient's legal status on their medicines chart.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff advised patients about their medicines during weekly reviews and also provided patients with medicine information leaflets.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff completed a weekly stock check of medicine and kept an up-to-date stock list. The hospital pharmacist checked expiration dates of stock and all medicines were in date.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The provider distributed 'patient safety action notices' to staff by email and in staff areas to make all staff aware.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff did not always review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Two patients who were prescribed high dosage anti-psychotic medicines did not have a care plan in place for monitoring the effects on their physical health. This was raised with the provider at the time of inspection and rectified. However, patients had their physical health monitored twice per day and staff provided access to electrocardiogram and blood tests where patients consented.

Track record on safety

The service had a good track record on safety.

Staff reported 128 incidents between April and June 2021 with the majority of incidents involving physical aggression and violence, and self harm.

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.

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 reported serious incidents clearly and in line with provider policy.

The service had no never events on the ward. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

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.

Managers debriefed and supported staff after any serious incident. The provider had a policy for the debrief process including patient feedback forms.

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. The ward held weekly team meetings where staff discussed incidents, learning and outcomes.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient on admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The consultant psychiatrist and a nurse met with patients on admission and completed a thorough assessment of mental and physical health needs. We reviewed five patient records and saw that this had been completed for all patients.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery orientated. Staff told us that when care planning they printed the document from the system to complete with the patient and then entered it onto the electronic system. However, staff told us that they often did not have time to do this due to the staffing levels on the ward.

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. Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. The provider employed physical health specialists including nurses, general practitioner, dentist and optician.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff used food and fluid charts to monitor patient's intake where required. There was a range of meal choices available for patients including healthy options.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scores and Recovering Quality of Life Scales to assess patient outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The provider had an annual audit plan. Audits over the past year included capacity assessments, Covid-19 care plans and rapid tranquilisation.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). 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 a full range of specialists to meet the needs of the patients on the ward. The ward team included a social worker, occupational therapist and occupational therapy technical instructor, a consultant psychiatrist and an associate specialist doctor, and nursing staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank staff.

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

Managers supported staff through regular, constructive appraisals of their work and 88% of staff had an up to date annual appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Staff received regular management supervision and also attended group reflective practice sessions.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Managers held weekly team meetings and monthly clinical governance meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Healthcare assistants could also apply for a nursing qualification and join the provider preceptorship programme. Managers recognised poor performance, could identify the reasons and dealt with these. The ward did not have any staff on performance monitoring at the time of inspection, but the provider had a capability policy in place.

Multi-disciplinary 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 team(s) 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. The ward held daily multidisciplinary meetings every morning and weekly ward round meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff held handover meetings at the start of day and night shifts to update staff starting shift on patients.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff worked closely with the local authority safeguarding team, commissioning groups and the local general hospital.

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 and discharged these well. 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. Compliance with Mental Health Act training was 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

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.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Compliance with Mental Capacity Act training was 100%.

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 gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Good

Our rating of caring improved. We rated it as 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. We observed episodes of care on the ward and saw that staff were caring and respectful to patients. Patients we spoke with told us staff were respectful and kind.

Staff gave patients help, emotional support and advice when they needed it. Staff demonstrated a person centred approach to patients and tried to ensure patient activities were personalised.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. We spoke with two patients and observed the weekly community meeting where patients could raise concerns. Patients did not raise any concerns about staff treatment of them.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff felt confident that they could raise any concerns with managers and that action would be taken as a result of their concerns.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their 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. Staff gave newly admitted patients a tour of the ward and met with them and the consultant to discuss their treatment. Staff provided a welcome booklet on admission and a pack of toiletries for patients to use. The ward had a supply of clothes for patients who had not arrived with additional clothing.

Staff involved patients and gave them access to their care planning and risk assessments. Staff completed risk assessments and care plans with patients but did not always fully record this or give patients a copy of their care plan. Patient voice was not evident within care plans. We reviewed five patient records and found that one care plan included patient views and had been offered to the patient.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff read patients their rights on admission and repeated this daily until patients could demonstrate they understood their rights. The hospital had access to translators and interpreters for patients who required them.

Staff involved patients in decisions about the service, when appropriate. Staff involved patients in decisions about ward activities and social events.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients completed a feedback form each week which the multi-disciplinary team discussed with the patient in weekly ward round reviews. Patients could also give feedback in the weekly ward community meeting. The provider held a monthly patient forum where patients could raise ideas or concerns.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Patients could access an independent mental health advocate who visited the ward regularly.

Involvement of families and carers

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with three family members of patients who all felt that they were kept up to date and received regular phone calls from ward staff. Families were invited to attend weekly ward round meetings by video or phone call and spoke highly of how staff involved them in patient care.

Staff helped families to give feedback on the service. The provider was in the process of setting up a virtual carers forum for families to give feedback and had recently introduced a newsletter that encouraged carer feedback.

Staff gave carers information on how to find the carer's assessment. Families spoke positively about the support they received from social workers within the hospital and how they had been offered accommodation and financial support to visit their family member on the ward.

Are Acute wards for adults of working age and psychiatric intensive care units responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. The average bed occupancy for the ward in the last year was 34% which was due to the ward operating as a long term segregation unit for one patient over a period of months. Since April 2021 the ward admitted patients back at a measured rate and the bed occupancy was 60% at the time of inspection. All patients admitted were nursed in isolation for a minimum of 48 hours to reduce the risk of Covid-19 transmission.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The service had no/low out-of-area placements.

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.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Discharge and transfers of care

The service had no delayed discharges in the past year.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff began discharge planning at the point of admission.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. 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.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions. Patients bedrooms had lockable cupboards and a safe to store valuable items.

Staff used a full range of rooms and equipment to support treatment and care. The ward included a television and games console room, lounge and dining area, art room and sufficient space for one to one and group meetings. There was a gym area and occupational therapy kitchen that patients could use dependent on risk and observation levels.

The service had quiet areas and a room where patients could meet with visitors in private. The ward had a designated meeting room for family and visitors and a quiet room.

Patients could make phone calls in private. Patients had access to their mobile phones subject to risk assessment or could use the ward cordless phone if necessary.

The service had an outside space that patients could access easily. The ward had two enclosed outside spaces, one of which was open to patient access all day. Patients could use electronic cigarettes that the ward provided in the outside space.

Patients could access cold drinks and snacks and staff offered hot drinks or provide them at patient request.

The service offered a variety of good quality food.

Patients' engagement with the wider community

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

Staff helped patients to stay in contact with families and carers. Patients could contact their family and friends by phone and video conferencing. The provider encouraged family visits by offering accommodation and financial support to visitors.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

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.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

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.

The ward had received two patient complaints and two patient compliments in the past three months. We reviewed both complaints and were assured that they had been investigated and resolved. Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

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

Local leaders at ward and directorate level had good knowledge and understanding of the service they managed and were visible on the ward for staff and patients.

Senior leaders above the directorate level were not usually visible on the ward although they had visited during the inspection. Senior leaders provided regular updates by email.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff could describe the provider values of Compassion, Accountability, Respect, Excellence and could evidence how they applied these values in their day to day work.

Culture

Staff felt respected, supported and valued by their local leadership. 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 reported that they felt supported and valued within the ward and directorate but that they often felt stressed and unsafe due to the staffing levels on the ward and the amount of time spent on enhanced observations. Staff felt able to raise concerns with their line managers but were frustrated that no action had been taken about staffing numbers by senior managers.

The provider offered development opportunities for staff including nursing qualification for healthcare assistants and three staff members were undertaking this at the time of inspection. Qualified nurses had the opportunity to develop into clinical nurse lead roles.

Governance

Our findings from the other key questions demonstrated that performance and risk were not managed well. Governance processes operated effectively at team level.

The provider had set planned numbers for staffing the ward that did not provide enough staff to cover patient enhanced observations safely. Staffing numbers were reviewed on a directorate level and when Bayley ward was staffed at optimum levels, staff were regularly reallocated to other wards to cover their unfilled shifts. Managers had not addressed staff allocation to patient observations for long periods or reliance on multi disciplinary staff to cover breaks.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

The provider used effective governance dashboards for managers to have an overview of performance.

The provider held regular governance meetings with a clear framework of what was discussed and how this was fed back to staff.

Management of risk, issues and performance

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

The provider had a directorate level risk register in place. The risk register matched the concerns of staff on the ward but had not addressed the main concern about set staffing levels.

Ward staff had access to the information they needed to provide safe and effective care and used that information to good effect. However, the provider did not use technology effectively for staff to record care planning and observation records with patients. Staff used paper records to complete these which were then uploaded or typed onto the electronic system.

Information management

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

The provider used a dashboard system to collect data from the ward, and this was not burdensome on staff. The provider used key performance indicators to monitor the ward that included training, incidents and restraint.

Inadequate

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Wards were not always safe, however, wards were clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff had easy access to alarms and patients had easy access to nurse call systems. However, alarms on Willow and Maple ward did not work consistently due to fluctuating Wi-Fi signals, and alarms were unreliable. We were concerned that this would affect staff and patient safety.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could not observe patients in all parts of the wards. Patients at greater risk were placed on enhanced observation to mitigate against this. However, enhanced observations were not always carried out effectively.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We reviewed the ligature risk assessments on each ward and saw that these were complete and up to date.

Maintenance, cleanliness and infection control

Staff generally followed infection control policy, including handwashing. However, four staff on Willow ward were observed to be wearing masks incorrectly. This was reported to managers as we were concerned that Personal Protective Equipment was not being used effectively.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed the cleaning records on all three wards during the inspection and saw that cleaning and deep cleaning was regularly carried out. All cleaning items were locked away when not in use and not left unattended.

Seclusion room

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

Staff did not always keep clear records or follow best practice guidelines in the use of seclusion. We reviewed the minutes of a serious incident sign off meeting dated 16 July 2021, which related to an episode when a patient was placed in seclusion. The minutes from the meeting stated that there had been poor record keeping and that the seclusion review policy had not been followed.

We viewed the long-term segregation area on Maple ward. This area consisted of a bedroom, en suite area, lounge area. There was an observation area for staff. Access to fresh air was limited to a small secure courtyard. At the time of our visit there were no patients in long-term segregation. There was a blind spot in the bedroom area. Where the patient's bed was located, the patients' head area was obscured. This did not allow staff to see the patient's full body. However, staff told us if a patient was being nursed in long-term segregation, they would always be within eyesight or on arms' length observations.

Clinic room and equipment

Clinic rooms were clean, fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment. Cleaning records were seen, and clean stickers were in place.

Safe staffing

Nursing staff

The service did not have enough nursing and support staff who knew the patients to keep people safe from avoidable harm. On Willow ward we found recorded evidence of incidents where patient observations had been missed and night staff had to remain on shift due to a lack of day staff. We reviewed an incident on Bracken ward whereby a patient was able to tie a ligature due to the day area being left unobserved.

The service had reducing vacancy rates of four qualified nurses and four health care assistants across the three wards.

Managers were not able to access as many bank and agency staff as required due to the impact of the pandemic and requested staff familiar with the service. However, covering staff were not always familiar with secure forensic services.

Managers couldn't always ensure that all bank and agency staff had a full induction and understood the service before starting their shift.

The service reported a staff turnover rate of 3% between 1 April 2021-30 June 2021.

Managers supported staff who needed time off for ill health by maintaining regular contact with them.

Levels of sickness were lower on Maple and Bracken ward and higher on Willow ward with two qualified nurses and one health care assistant off sick at the time of inspection.

Managers did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. We reviewed 10 shift planners on Willow ward and found that in seven cases, no nurse was identified to respond to an emergency. The ward manager could not always adjust staffing levels according to the needs of the patients.

Patients and staff that we spoke with, said that sometimes escorted leave or activities were cancelled when the service was short staffed. Patients who wanted to attend the Recovery College often couldn't, due to a lack of escorting staff.

Managers had not ensured that staff who covered for ward shortages had a full induction and understood the service before starting their shift. On Bracken ward we observed that a newly employed staff member had never been on the ward and was unfamiliar with the nature of the service. Staff did not have sufficient time to provide an induction or handover.

Staffing levels were routinely low across all three wards and staff, patients and managers reported that low staffing was a frequent occurrence. The provider advised this was due to the impact of the pandemic. However, regulatory action has been taken against this core service for breaches relating to low staffing levels on three separate inspections between July 2018 and March 2020. On Bracken ward on 8 July the ward was one staff member short; on Maple ward we observed the ward manager had to sit in the lounge as there were no other staff free on the ward. We observed that staff were not always able to get their breaks.

Staff on Willow and Maple ward did not routinely respond to alarms when an emergency happened on another ward. We observed that staffing levels did not facilitate their ability to leave the ward to support staff in an emergency. This placed both patients and staff at risk.

The ward managers could not always adjust staffing levels according to the needs of patients. Whilst managers could request additional staff, these were not always provided so the shift continued with reduced staffing levels.

Patients did not always have a regular one to one session with their named nurse. Managers told us that other staff would provide a one-to-one session if the named nurse was not available.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Handovers took place at the beginning of each 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. The service had an on-call rota system for out of hours medical cover. Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff completed and kept up to date with their mandatory training. This was at 92% at the time of the inspection.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Ward managers monitored mandatory training via an easily accessible dashboard and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. However, they had not always 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 good 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 failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed the risk assessments of 16 patients during the inspection.

Staff completed risk assessments for each patient on admission or very soon after, using a recognised tool. Patient risk assessments were reviewed regularly by the multi-disciplinary team and additionally after any incident.

Management of patient risk

Staff who were familiar with the wards knew about any risks to each patient. However, staff did not always act to prevent or reduce risks. Staff did not always carry out enhanced observations correctly. As a result, patients were left unsupervised for periods of time and came to harm. We found two examples of this on Willow ward resulting in patients requiring treatment at the acute hospital.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. We reviewed an incident on Willow ward that occurred in July 2021 as a result of staff not following the patients care plan. The patient subsequently required emergency treatment at the acute hospital. We reviewed an incident on Willow ward that occurred in May 2021 where staff did not respond effectively when a patient refused food and then fluids. This resulted in the patient being admitted to the acute hospital for rehydration. The acute hospital raised this concern as a safeguarding for investigation.

Willow ward reported 35 incidents of patients self-harming whilst on enhanced observations from 1 April 2021 to 30 June 2021. Of the 35 incidents, 21 occurred when patients were on arm's length observations.

Staff could not observe patients in all areas of the wards. Staff did not always follow procedures to minimise risks where they could not easily observe patients.

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Patients were routinely searched on their return from leave.

Inadequate

Forensic inpatient or secure wards

Use of restrictive interventions

Levels of restrictive interventions were reducing.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques such as verbal de-escalation, distraction and Dialectical Behavioural Therapy. Staff restrained patients only when these failed and when it was necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. This included at least hourly monitoring of patients' physical health and vital signs until staff were assured that there were no concerns.

When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. This was evidenced in an incident review which highlighted a lack of seclusion reviews and poor recording. Reviews on Willow ward were not always carried out or recorded in patient records for patients who were 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.

We saw evidence of blanket restrictions on Bracken ward. We reviewed the providers restrictive practice log which evidenced these restrictions were in place due to specific, individual patient risks on the ward at the time. However this meant patients could not make hot drinks and snacks independently of staff. All drinks were kept in the office and patients had to ask staff to make them. Patients could not access fresh air whenever they wanted, the courtyard was kept locked and patients had to ask staff to open it. This only took place when there was a staff member available to supervise. Patients could only vape three times each day and could not vape before bedtime.

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. They were able to give clear examples of potential safeguarding issues and knew how to escalate this.

Staff kept up to date with their safeguarding training. The provider reported a compliance rate of 98% for level one and two safeguarding training and 93% for level three safeguarding training as of June 2021.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff described an improved relationship with the local authority safeguarding team and were in regular contact with them.

Staff followed clear procedures to keep children visiting the ward safe. The hospital social worker booked a suite on the ground floor to facilitate hospital visiting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward staff approached ward managers or the safeguarding lead if they needed to.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely, either electronically or in the locked nurse's office.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

We reviewed 17 prescription charts during the inspection.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Information was recorded on all prescription charts on patient allergies.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The pharmacist visited the wards bimonthly.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Track record on safety

The provider reported 721 incidents for this service between 1 April 2021-30 June 2021. Willow reported the most with 587, Maple reported the least with 20. The most common incident type was 'Self harm' accounting for 154 reported incidents.

Inadequate

Forensic inpatient or secure wards

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents, 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.

Staff knew what incidents to report and how to report them. They gave examples of incidents that happened and described how to record them on an electronic recording system.

Senior managers did not sign off incident reviews until actions plans were created to address recommendations. Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. We saw examples of this during the inspection.

Managers debriefed and supported staff after any serious incident. Managers contacted staff at home after their shift to check on their wellbeing and weekly reflective practice sessions focussed on specific incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. There was a monthly bulletin circulated to staff.

Staff met to discuss the feedback and look at improvements to patient care. These discussions took place at staff meetings.

There was evidence that changes had been made as a result of feedback. Managers gave the example of increased safety checks and improved documentation as a result of incidents.

Are Forensic inpatient or secure wards effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. They included specific safety and security arrangements and a positive behavioural support plan.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We saw evidence of this in patient records.

We reviewed 16 patient records during the inspection. Care plans were personalised, holistic, and recovery orientated, and patients were routinely offered a copy of their care plan.

Staff regularly reviewed and updated care plans when patients' needs changed.

Inadequate

Forensic inpatient or secure wards

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. 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.

Staff delivered care in line with best practice and national guidance including the National Institute of Health and Care Excellence. We saw in patients' prescription charts that medication health checks and medication levels were routinely checked.

Staff identified patients' physical health needs and recorded them in their care plans. Support workers facilitated healthy eating and cooking groups. Staff ensured that patients had access to physical health care, including specialists as required. One patient had sleep apnoea and the necessary equipment had been provided to monitor this.

Staff did not always meet patients' dietary needs, and correctly assess those needing specialist care for nutrition and hydration. We reviewed an incident from May 2021 where a patient on Willow ward was admitted to the acute hospital for treatment due to staff not responding to their needs.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included Health of the Nation Outcome Scales and Health of the Nation Outcome Scales secure.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used the results from audits to make improvements.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the wards. However, activities and therapies were routinely cancelled due to low staffing numbers and therapy staff having to provide cover on the wards. We saw evidence of activities being cancelled in community minutes on Willow ward.

Managers had not ensured that staff had the right skills and experience to meet the needs of the patients. New and inexperienced staff were being sent to Bracken ward to provide cover due to staff shortages. We observed this on 8 July 2021 and observed that staff had insufficient time to give new covering staff a handover.

Managers gave each new member of staff a full induction to the service before they started work. However, covering staff were not always familiar with working in secure forensic wards.

Managers supported staff through regular, constructive appraisals of their work. The provider reported a compliance rate of 100% for appraisals as of May 2021

We requested supervision data, which was not initially provided. However, we subsequently received data which reported a compliance rate in May 2021 of 75% for management supervision and 79% for clinical supervision.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Team meetings took place regularly. Lessons learned were discussed at team meetings and reflective practice sessions but were not always embedded within teams or reflected in improved practice.

Managers identified any training needs their permanent staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure permanent staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

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 team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early in the patient's admission to plan discharge.

Staff did not always provide clear information about patients to staff arriving part way through a shift to support the ward. However, staff made sure they shared clear information about patients and any changes in their care at shift handovers and within the weekly multi-disciplinary team meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Managers highlighted that they worked to improve relationships and communication with the local authority safeguarding team.

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

Staff fully understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

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 had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated this as necessary and recorded it clearly in the patient's notes each time.

Staff couldn't always ensure that patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. This was due to routinely low staffing levels on the wards.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Audits were routinely carried out by the Mental Health Act administrators.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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.

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. They could speak to qualified staff or contact the Mental Health Act Administrator on site for guidance.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Inadequate

Forensic inpatient or secure wards

Are Forensic inpatient or secure wards caring?

Requires Improvement

Our rating of caring improved. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff had not always treated patients with compassion and kindness or respect patients' privacy and dignity.

A patient on Bracken ward was unable to get to the toilet in time due to a delay in staff assistance. Staff apologised to the patient about this incident.

Staff generally gave patients help, emotional support and advice when they needed it.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said that staff generally treated them well and behaved kindly.

Staff did not always appear to understand the individual needs of patients or support patients to understand and manage their care treatment or condition. This was evidenced when staff did not always provide enhanced observations as prescribed.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Patient records were stored electronically or in lockable filing cabinets in the nurse's office.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their 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. They were given orientation to the ward and to the systems and routines.

Staff involved patients and gave them access to their care planning and risk assessments. Patients were offered a copy of their care plan although many declined.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). This included daily provision of interpreters for two deaf patients on Maple ward.

Staff involved patients in decisions about the service, when appropriate.

Inadequate

Forensic inpatient or secure wards

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held weekly, and patients were invited to attend their multi-disciplinary team meetings.

Staff supported patients to make advanced decisions on their care.

Staff ensured that patients had easy access to independent advocates. We saw posters and leaflets and patients told us that the advocate regularly attended the ward.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with six carers during the inspection. All six gave positive feedback about the staff. Most said that they received good communication from the staff and that information was always forthcoming.

Staff helped families to give feedback on the service. There was an annual feedback questionnaire and carers were also invited to feedback at the carers' forum.

Staff gave carers information on how to find the carer's assessment.

Are Forensic inpatient or secure wards responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%. The bed occupancy at the time of inspection was 73%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay was 634 days.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had two delayed discharges in the past year.

Managers monitored the number of delayed discharges.

The only reasons for delaying discharge from the service were clinical.

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. 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. However, not all patients could make hot drinks and snacks at any time.

Each patient had their own en suite bedroom, which they could personalise. We saw examples of this during the inspection where patients had their own duvet covers, photographs, posters and music collections.

Patients had a secure place to store personal possessions. We saw patients routinely accessing secure lockable lockers just off the wards.

The service had a full range of rooms and equipment to support treatment and care. This included a sensory room for patients who would benefit from its use, including those on the Autistic spectrum. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Some patients had mobile phones following an individual risk assessment.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

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. Patients and staff that we spoke with told us about a local facility in which they could work in the kitchen, go to the coffee shop or make cakes.

Staff helped patients to stay in contact with families and carers. Most of the carers that we spoke with said that they had regular contact with the service and with their relative.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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 supported and made adjustments for disabled people and those with communication needs or other specific needs. Staff ensured that two deaf patients had an individual interpreter throughout each day. A staff member who was deaf also had an interpreter working alongside them during each shift.

Wards supported disabled patients. All wards had disabled bedrooms and wide corridors for wheelchair access.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This was displayed on each ward notice board.

The service had information leaflets available. Ward managers told us that these could be made available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters when needed. We saw evidence of this on Maple ward.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. This included, halal, kosher, vegan, vegetarian and gluten free.

Patients had access to spiritual, religious and cultural support. We saw that spiritual leaders visited the patients regularly and spoke with them during the inspection.

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.

The service clearly displayed information about how to raise a concern in patient areas. A carer told us that they understood the complaints process and would feel confident to us it.

Staff understood the policy on complaints and knew how to handle them.

Managers shared feedback from complaints with staff through staff meetings, bulletins and supervision and learning was used to improve the service. We reviewed the lessons learned folder held on each ward.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Inadequate

Forensic inpatient or secure wards

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Are Forensic inpatient or secure wards well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

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

Vision and strategy

Staff knew and understood the provider's vision and values. However, staff did not always apply them in their teams.

The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were compassion; be supportive; understand and care for our patients, their families and all in our 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. Staff knew and understood the provider's vision and values, but they were not always applied in the work of their teams.

Culture

The provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff felt able to raise concerns without fear of retribution.

Staff often missed breaks and routinely worked on wards that were short staffed. However, they reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. Staff were aware of the whistleblowing policy, where to find it and how to use it. However, staff did not always feel respected, supported and valued.

Governance

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

Some of the concerns raised at the previous inspection such as staffing, enhanced observations, dignity and respect to patients, patient's physical healthcare and blanket restrictions had not been fully addressed.

Inadequate

Forensic inpatient or secure wards

Staffing levels remained routinely low and the system in place for managing this was ineffective and placed patients and staff at risk. Senior leaders were aware of the staffing issues on all wards and had not acted upon this despite staff and ward managers having raised concerns and serious incidents occurring. Senior leaders acknowledged during the inspection that safe staffing levels had not been maintained.

The provider's data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

Senior leaders did not ensure that staff with sufficient skills, knowledge, and experience were provided for the women's forensic service. Staff were sent to provide cover when they had no experience of forensic wards and were newly in post.

Observations were not always carried out in line with patients care plans and risk and the provider did not have a robust system in place to ensure that this did not reoccur.

The provider did not investigate all incidents thoroughly and provide a clear action plan in order to learn from previous incidents and promote the embedding of change within the service.

Information management

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

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. Managers from the service participated actively in the work of the local transforming care partnership.

Inadequate

Wards for people with learning disabilities or autism

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

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in nearly all areas of the wards. We found one blind spot in the bathroom on Church ward. We were told that this had been escalated to estates but no date was given as to when this would be resolved. Blind spots were mitigated by the installation of mirrors. We were told no patients use the shower in this bathroom where the blind spot was.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried these on their belt and if activated pinpointed their location. Staff called for further assistance across the site using a radio.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Dedicated domestic staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Seclusion room

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

Seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice. We viewed the seclusion rooms on all three wards. The blind to the seclusion room's window on Church ward was in the closed position. Staff were unable to open the blind at the time of our visit. The provider later told us the tool to operate the blind was kept in the nurses office.

When viewing the Oak ward seclusion room, we found that closed circuit television cameras were located in the bedroom and en suite areas in the seclusion suites. The viewing screens were located in the observation corridor outside. Staff told us the screens were switched on all the time therefore patients could always be seen. However, bathroom privacy would be individually risk assessed for each patient. Patients who had been in seclusion for a long time were able to personalise the area.

We viewed the seclusion room on Sycamore ward. We found that plaster was peeling off a wall in the bedroom area and there were stains on the wall and ceiling. Staff told us these stains were from blackcurrant juice.

We viewed the long term segregation area on Sycamore ward. This area consisted of a bedroom, en suite, lounge area and a small secure courtyard area for access to fresh air. There was an observation area where staff were provided with seating. The only storage the patient had was drawers located at the bottom of the bed.

Clinic room and equipment

Clinic rooms were fully equipped, with emergency drugs that staff checked regularly. Wards had access to resuscitation equipment.

Staff checked, maintained, and cleaned equipment.

Clinic room temperatures were not always below the recommended 25 degrees for the safe storage of medicines. The clinic room on Oak ward regularly had a temperature of 25.4 to 34.3 degrees centigrade. This was above the recommended temperatures for the safe storage of medicines. Staff told us this had been the same since the ward moved to the new location earlier this year, and pharmacy staff were aware but no action had been taken.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients well. Staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We reviewed seven daily shift planners on Church ward from 1 July 2021 to 7 July 2021 which stated that that one patient had their enhanced observations reduced from 1:1 continuous observations to 15 minute intermittent observations on four separate occasions. We were told by staff and the patient this was due to staff shortages. We reviewed one daily shift planner on Oak ward which

stated that on the night shift of 1 July 2021 one patient had their enhanced observations reduced from 2:1 continuous observations to 1:1 continuous observations for four hours. We were told this was because the ward was below safe staffing numbers and a discussion was held with the bleep holder who made the decision to do this. We were told by 13 out of 17 members of staff that staffing was an issue and the wards were regularly short staffed.

The vacancy rate for staff varied across wards. Oak ward reported a vacancy rate of 51% for qualified staff as of 06 July 2021. For the same time period Church ward reported a vacancy rate of 11% for qualified staff. Sycamore ward reported no qualified staff vacancies. Oak ward reported a vacancy rate of 9% for unqualified staff as of 6 July 2021. For the same time period Sycamore ward reported no unqualified staff vacancies. Church ward over-recruited for unqualified staff by 36%.

The service increased its use of agency staff. Between 1 April 2021 and 30 June 2021 qualified agency staff covered 2% of available shifts for staff across the three wards. For the same period unqualified agency staff covered 3% of available shifts across the three wards.

The service increased its use of bank staff. Between 1 April 2021 and 30 June 2021 qualified bank staff covered 8% of available shifts for staff across the three wards. For the same period unqualified bank staff covered 32% of available shifts across the three wards.

The service was not able to fill all required shifts. Between 1 April and 30 June 2021, 45 shifts (25%) were not filled across the 182 shifts. The provider told us this represents less than 0.3% of the total planned shifts.

Managers told us they tried to request staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates. Between 1 April 2021 and 30 June 2021 Oak ward and Sycamore ward reported a turnover of 1%. Church ward reported no turnover for the same time period.

Managers supported staff who needed time off for ill health. Levels of sickness were high and increased across the three wards. Between 1 April and 30 June 2021 the provider reported an average sickness rate of 18% on Sycamore ward, 9% on Church ward and 8% on Oak ward. We spoke to one staff member who told us five staff were injured and needed hospital treatment in the first month of Sycamore ward opening.

Divisional leaders did not accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Due to the wards being short staffed, ward managers were regularly included in the staffing numbers to increase the number of nurses required for that shift.

Staffing levels did not allow patients to have regular one to one sessions with their named nurse.

Patients regularly had their escorted leave, or activities cancelled, due to the ward being short staffed. Eight staff told us they had to cancel patient escorted leave or cancel activities due to the wards being short staffed. Two patients told us they had their escorted leave or activities cancelled due to the wards being short staffed, only one of these patients told us this was then rearranged. Four patients told us the wards were short staffed. One patient said there was not a lot to do on the ward.

The service did not always have enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The provider reported a whole-time equivalent vacancy rate of 20% for doctors. Of the patients we spoke with, one patient told us that doctors are busy, and they can go for weeks without seeing a doctor.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. Permanent staff had an overall compliance rate of 94% across the three wards. Non-permanent staff had a compliance rate of 90% for June 2021.

The mandatory training programme was comprehensive but did not meet the needs of patients and staff. Learning disability and autism training was not mandatory for these wards and only two non-permanent staff completed the introduction to autism training from April 2021 – July 2021. Staff had not completed training in relation to learning disabilities.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. However, staff had the skills to develop and implement good 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 failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly electronically, including after any incident.

Staff used a recognised risk assessment tool.

Management of patient risk

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others.

Staff did not always act to prevent or reduce risks despite knowing the risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy.

Managers allocated staff to complete enhanced observations continually on Church ward for patients who required it for between three and ten hours on 33 occasions between 1 and 7 July 2021. Managers allocated staff to complete enhanced observations continually on Oak ward for patients who required it for between three and ten hours on 18 occasions between 3 and 8 July 2021.

Staff were allocated to complete enhanced observations for the same patient for between three and ten hours at a time on Church ward, on 13 occasions between 1 and 7 July 2021. We found that staff were allocated to complete enhanced observations for the same patient for between three and five hours at a time on Oak ward, on two occasions on 3 July 2021.

Staff had not carried out patients' observations at the intervals prescribed. We reviewed observation records for one patient from 2 July to 6 July 2021. We found that the intervals in between this patient's observations exceeded their prescribed observation interval three times. We reviewed observation records for another patient on 6 July 2021. We found that the intervals in between this patient's observations exceeded their prescribed observation interval six times. We reviewed observation records for a patient on 8 July 2021. We found that the intervals in between this patient's observations exceeded their prescribed observation interval of five minutes once for a period of 15 minutes.

We reviewed five patient observation records. We found staff observed at regular intervals for 44% of the time (187 hours out of 425 hours).

This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety. We found issues with the use of enhanced observations on Oak and Church wards we visited.

We observed two staff retrospectively completing observation records twice on 6 July 2021. We were told by one member of staff that although observations are carried out at the prescribed time, observations are sometimes signed in one go due to staff shortages and a lack of time.

Wards had blanket restrictions in place. Patients on Oak ward had to ask staff for a drink and did not have access to facilities to make their own without staff support. We were told if they were kept in the communal area they may be thrown during an incident or have would have to be moved should an incident occur in that area. Both Oak ward and Church ward had set vape times where the patients were able to vape in the courtyard. Patients on Oak ward had to ask staff for toilet roll each time they wanted to use the toilets in the communal areas.

Use of restrictive interventions

Levels of restrictive interventions were high but reducing. Between 1 April 2021 and 30 June 2021, the provider reported 311 incidences of restraint. Oak ward had 148 incidences of restraint while Church ward had 41 incidences of restraint. The use of restraint had reduced by more than half on these wards since our previous inspection. Sycamore ward had 122 incidences of restraint despite only having one patient on the ward.

Levels of prone restraint were high on Sycamore ward. Between 1 April 2021 and 30 June 2021 the provider reported 13 incidences of prone restraint on Sycamore ward. Oak ward and Church ward reported no incidences of prone restraint for the same time period.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

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.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Between 1 April 2021 and 30 June 2021 the provider reported 11 incidences of administering rapid tranquilisation. The highest was on Sycamore ward (seven) followed by Oak ward (three) and then Church ward (one).

We reviewed data provided that indicated the use of seclusion had decreased over the last 12 months. Between 1 April 2021 and 30 June 2021, the provider reported there had been 100 instances of seclusion. The highest was on Church ward (38) followed by Oak ward (34). Sycamore ward reported 28 instances of using seclusion relating to one patient.

When a patient was placed in seclusion, staff did not always follow best practice guidelines. We reviewed the records of a patient who was currently being nursed in seclusion since 20 October 2020. On the day of our visit the patient was being supported to reintegrate with the patients on the main ward and also had a 'shared lunch' with the multidisciplinary team. We were unclear why this patient was not being nursed in conditions of long-term segregation. The notes indicated periods where the patient did not meet the definition of seclusion as defined in Mental Health Act Code of Practice. Section 26.103 states that 'seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others'. The records showed the patient was accessing fresh air depending on risk and engaging with the multidisciplinary team. The patient started to reintegrate with the main ward population and we saw evidence of the patient attending a community meeting. The patient's care plan stated '…plan to reintegrate patient slowly into the main area of the ward, as Oak does not have a long term segregation area that is robust enough for the patient and her challenges are still high'. The patient's care plan did not clearly state what needed to happen for seclusion to end. Staff used the term long-term segregation and seclusion interchangeably in the patient's progress notes.

We reviewed the seclusion paperwork of one Sycamore ward patient. We found the paperwork met some, but not all of the guidance in the Mental Health Act Code of Practice. For example, we were unable to find evidence of a medical review taking place within one hour or without delay if the patient is not known or there is a significant change from their usual presentation. We were unable to find evidence of an independent multidisciplinary team review taking place after the patient's eight hours of consecutive seclusion.

In relation to two Church ward patients being cared for in long-term segregation, staff followed guidance in the Mental Health Act Code of Practice.

We found clear rationale for the use of long-term segregation for a Church ward patient in the extra-care suite on Fenwick ward. However, we noted that long-term segregation would end when a suitable bespoke community placement was identified. Therefore, this meant the patient would remain in long-term segregation indefinitely. We reviewed minutes of an external review that took place in February 2021 and recommended that long term segregation was no longer proportionate and a plan should be in place to reintegrate the patient back on the ward. The multi disciplinary team discussed this recommendation and decided not to follow it due to concerns about the patient's risk to others and the impact on their anxiety levels. There was evidence of commissioner involvement and agreement with this decision.

When a patient was placed in long term-segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice. We reviewed the long-term segregation paperwork of a Sycamore ward patient. We found the roles of staff involved in the decision for long-term segregation were not recorded. The criteria to allow the patient's long-term segregation to end, including the interventions, was present in the records, however, there was no evaluation of the efficiency of the interventions or whether they were completed. In the patient's observation record, over three days, there were gaps in the recording amounting to 32 hours. There was no record of the daily responsible clinician's

review on ten occasions. There were no records of the weekly multidisciplinary team's review on six occasions. In a review by an independent senior professional, consideration had been given to move the patient to another ward, however, internal and external services declined this. A further review by an independent senior professional referred to the patient's plan towards community discharge, however, there was no information about this. At the time of inspection there was only one patient on Sycamore ward and they were being nursed under long term segregation. After the inspection the provider advised long term segregation would end when another patient was admitted.

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 mostly kept up-to-date with their safeguarding training. Permanent staff across all three wards had a compliance rate of 96.8% for safeguarding level one and two training. Permanent staff on Sycamore ward had a compliance rate of 60% for safeguarding level three training. Permanent staff on Church ward had a compliance rate of 90.9% for safeguarding level three training and permanent staff on Oak ward had a compliance rate of 100% for safeguarding level three training. Non-permanent staff had a compliance rate of 93.1% for safeguarding children, young people and adults (Level 1 and 2) training in June 2021 and a 100% compliance rate for safeguarding level 3 training.

Staff could give clear examples of how to protect patients from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Each ward had a dedicated family visitors' room within the building which could be booked in advance so managers can ensure staff are available to attend.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff did not make safeguarding referrals when patients were cared for in long term seclusion. We found no evidence of this.

Managers did not take part in serious case reviews and make changes based on the outcomes. We found no evidence of this.

Staff access to essential information

Staff had easy access to clinical information. Staff maintained electronic high quality clinical records. However, paper copies were not always up to date.

Patient notes were comprehensive, and all staff could access them easily.

The service used a combination of electronic and paper records across both wards. The paper records on Oak ward were not up-to-date. We were told staff rely on the paper records to support patients safely and effectively. However, we could see the electronic records were regularly updated across both wards.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All patient medication administration charts are stored on an online computer system. One staff member told us this system does go down at times which causes issues with administering medications.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Clinical Excellence guidance.

Track record on safety

The provider reported 487 incidents for this service between 1 April 2021-30 June 2021. Oak reported the most with 219, Church reported the least with 76. Sycamore ward (with one patient) reported 192. The most common incident type was 'Physical aggression and violence' accounting for 242 reported incidents followed by self harm accounting for 188.

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.

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 reported serious incidents clearly and in line with provider policy.

Inadequate

Wards for people with learning disabilities or autism

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Two patients told us they get feedback from these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. Care plans reflected the assessed needs, were personalised, holistic and strengths based. However, staff did not always involve families and carers.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients did not have their physical health assessed in a timely way on admission. However, patients regularly had their physical health reviewed during their time on the ward and had an up-to-date hospital passport. Staff ensured that they identified patients' physical health needs and recorded them in their care plans during reviews and made sure patients had access to physical healthcare, including specialists.

Staff did not always regularly review and update care plans and positive behaviour support plans when patients' needs changed. We reviewed 12 patient records. One positive behavioural support plan stated it should have been reviewed in January 2021 but had not been reviewed at the time of our inspection. Staff had not updated one epilepsy care plan since February 2020. However, staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Patient care plans did not always contain the right patient name on Oak ward. We found the wrong patient name written in patients' personal emergency evacuation plans four times and written in patient care plans once. We found the mental health act paperwork for one patient filed in another patients' online records.

Staff on Oak ward did not always have access to the most up to date patient care plans. All of the paper versions of the care plans we viewed on Oak ward were not the most up to date care plans as viewed on the patients' electronic record. We were told by two staff on Oak ward that staff relied on the paper versions of patient care plans rather than the electronic patient record. However, care plans were personalised, holistic and strengths-based.

Positive behaviour support plans were present and supported by a comprehensive assessment.

Best practice in treatment and care

The provider described the service as supporting patients with a learning disability and/or autism in a way that was person centred and addressing holistic needs, however staff did not always provide a range of treatment and care for patients based on national guidance and best practice for this service. Staffing shortages meant that access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation was at times, limited. Staff supported patients with their physical health and encouraged 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 did not always provide a range of care and treatment suitable for the patients in the service. There was a comprehensive therapy timetable available which staff were unable to carry out on Oak ward due to multidisciplinary staff being counted in numbers on the ward as the ward was so short staffed. We were told by eight out of 17 members of staff across both wards, that multidisciplinary staff were regularly required to work within the ward numbers, and this had been requested by the senior management team. This meant that patients missed out on having regular therapies. Three members of staff told us it was now an expectation of the senior management team to work within the ward numbers but they were also being challenged by the senior management team to continue providing therapies at the same time, which was not always possible. Staff told us they felt there was not enough importance put on therapies by the senior management team. The multidisciplinary team on Church ward were not counted in staffing numbers as often and so patients received more therapies on this ward. We reviewed 14 community meeting minutes for Church ward and Sycamore ward. It had been documented in eight of the community meeting minutes that patients said that they missed out on all or some of their therapy sessions due to short staffing.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg National Institute for Health and Care Excellence).

Staff understood patients positive behavioural support plans and provided the identified care and support.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients.

Managers took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

Managers did not always ensure staff had the range of skills needed to provide high quality care, or offer opportunities to staff to update and further develop their skills. However, the ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers supported staff with appraisals. Managers provided an induction programme for new staff.

The service had access to a full range of therapy staff. However, managers did not make sure all staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including non-permanent and agency staff. Managers did not make sure staff received any specialist training for their role. We were told that non-permanent staff were split into divisions across the hospital and the learning disability and autism division covered Oak and Church wards. We were told that non-permanent staff in the learning disability and autism division did not require learning disability or autism training. This meant that staff could be working with patients without the knowledge or skills to support patients with their required needs.

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

Managers supported most staff through regular, constructive appraisals of their work. As of 24 May 2021, the overall appraisal rate for staff within this service was 80%. The ward with the lowest appraisal rate was Oak ward with an appraisal rate of 70%. Church ward had an appraisal rate of 80% and Sycamore ward had an appraisal rate of 90%.

We requested supervision data, which was not initially provided. However, we subsequently received data which reported a compliance rate in May 2021 of 83% for management supervision and 67% for clinical supervision.

Managers did not make sure staff attended regular team meetings. We were told as the wards were short staffed, team meetings did not happen as regularly as they should. We did not see any evidence of recent team meetings on Oak ward.

Managers did not always give staff the time and opportunity to develop their skills and knowledge. Three staff told us that training regularly had to be cancelled due to staffing shortages on the wards.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary 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 staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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 and discharged these well. 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. Permanent staff across all three wards had a compliance rate of 92.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training. Non-permanent staff had a compliance rate of 84.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time.

Staff could not always facilitate patients taking section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Eight staff told us if the wards were short staffed, staff were unable to facilitate patient escorted leave. One carer told us there had been times when patient section 17 leave hasn't been supported due to staff shortage or the patient had an incident and their leave was cancelled.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Patient's Mental Health Act detention paperwork was not always clear. We looked at the Mental Health Act detention paperwork of one patient. On the patient's "Section 20 – renewal of authority for detention" (Form H5) that profession of the person being consulted had been omitted (part one of the form). In part two of the same form, the profession was entered as "SSN". Whilst we were aware this meant "senior staff nurse", other readers may not be aware of this. We discussed this with the provider's mental health law team leader. However, the detention paperwork was complete and appeared to be in order.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Inadequate

Wards for people with learning disabilities or autism

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Permanent staff across all three wards had a compliance rate of 92.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training. Non-permanent staff had a compliance rate of 84.7% for Mental Health Act, Mental Capacity Act and Deprivation of Liberty training.

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 gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed to the Mental Capacity Act and acted when they needed to make changes to improve.

Are Wards for people with learning disabilities or autism caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness. Not all, staff respected patients' privacy and dignity. Not all staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Not all patients said night staff treated them well and behaved kindly. Three patients on Church ward told us night staff were rude. One patient on Church ward told us that she had sworn at staff and they had sworn back at her. One patient on Church ward told us that night staff ignore them. One patient on Church ward told us that night staff sometimes come in chewing gum. Two patients on Church ward told us that night staff bring their mobile phones onto the ward and use them. One staff member told us she had seen night staff on Oak ward use their mobile phone on the ward. Mobile phones and chewing gum are contraband items on the wards. One patient told us on Church ward and two patients on Oak ward told us that night staff fall asleep on night shifts whilst doing their enhanced observations. We raised these concerns with senior managers who told us they would look into them and provide more detail and what had been done the following day but this was not provided.

Staff did not always consider patients' dignity when in seclusion. If patients were secluded for a prolonged period on Oak or Sycamore wards, they were expected to use the mattress, floor or their laps to eat. We were concerned that this potentially could compromise patients' dignity.

One carer told us not all staff treat their relative with respect.

Day staff were discreet and respectful when caring for patients. We observed day staff treating patients with respect, kindness and dignity. We spoke with one patient (with two staff present). The patient told us the staff were good and she saw her doctor every day. The patient was complimentary about the independent mental health advocate and told us she was supported on the telephone and more recently face to face contact restarted. Staff supported her to get fresh air and keep in touch with her family.

Staff were not always responsive to patient needs. One staff member told us that a patient had to wait for personal care as they were busy with another patient and the ward was short staffed. Two patients on Oak ward told us night staff denied them a drink during the night. One patient told us she had been denied a drink because night staff were asleep.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff tried to involve patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff sat with patients to get their input into their care plan, however the design and layout of care plans did not reflect the needs of people with a learning disability and/or autism. Two patients told us they did not have a copy of their care plan and one patient specifically said they would like a copy.

Not all staff had access to the appropriate communication resources to enable effective communication and to support patients to understand their care. We witnessed staff trying their best, but therapy staff had sole access to the resources required.

Staff involved patients in decisions about the service, when appropriate. Staff sought patient views during a relocation of the service to design the environments of the new wards.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff introduced patients to the ward and the services as part of their admission.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Inadequate

Wards for people with learning disabilities or autism

Staff did not always inform and involved families and carers appropriately.

Staff did not always support, inform or involve families or carers. Two carers told us they had not been invited to attend any of their relative's meetings.

Staff helped families to give feedback on the service and followed the principles of Ask, Listen, Do in relation to feedback, concerns and complaints.

Staff did not always give carers information on how to find the carer's assessment. Three carers told us they had never received any information about a carer's assessment.

Are Wards for people with learning disabilities or autism responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff planned and managed discharge well. Staff liaised well with services that would provide aftercare. Discharge was rarely delayed for other than a clinical reason. However, some patients had excessive lengths of stay.

Bed management

We reviewed bed occupancy rates from June 2020 to June 2021. The bed occupancy rate for Church ward was 105%. The bed occupancy rate for Oak ward was 91%. The bed occupancy rate for Sycamore ward was 25%.

We reviewed patient's average length of stay from June 2020 to June 2021. Patient's average length of stay on Oak ward was 1667 days. Patient's average length of stay on Church ward was 1134 days. Sycamore ward opened in April 2021, therefore no patients had been discharged.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. Oak ward had four delayed discharges. Church ward had one delayed discharge. No patients had been discharged from Sycamore ward.

The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment. Not all patients could make hot drinks and snacks at any time. However, each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were some quiet areas for privacy. The food was of good quality.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and had access to a room where patients could meet with visitors in private.

The service had not fully responded to the needs of patients with autism in the ward environment. Patients on Oak ward did not have access to a sensory room. There was a room allocated to this and the sensory equipment was on site, but we were told due to COVID-19 the work required for the room to be used had been delayed. Patients on Church ward had access to a sensory room and we spoke to patients who told us they had been involved in painting the room, but the room was not yet fully furnished. However, patients on both wards did have access to sensory equipment they could use.

One staff member told us the ward was noisy.

Patients could make phone calls in private.

Patients could not freely access the outside space on Oak ward. The door was kept locked unless a patient asked to access this area. Four staff on Oak ward told us that patient access to fresh air was dependent on staff availability. Patients told us they were able to access outside areas when they wanted. Church ward had an outside space that patients could access easily.

Patients still could not make their own hot or cold drinks and snacks and were dependent on staff to make these for them on Oak ward. Patients on Church ward could make their own and had access to hot and cold drinks and snacks.

The service offered a variety of good quality food.

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. Patients told us about their education and work commitments.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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. Staff devised communication plans for patients with communication needs. Staff used social stories and easy read versions of information to support patients.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service could access information leaflets in multiple languages and formats to meet patients' communication needs.

Managers made sure staff and patients could get help from interpreters when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

We reviewed complaints and concerns during the site visit. 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.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints.

We were unable to find evidence that complaints were formally analysed to identify themes, trends and identify lessons learned. Complaints were recorded separately in individual patient files so there was no oversight of complaint trends.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Inadequate

Wards for people with learning disabilities or autism

Managers shared feedback from complaints with staff but two patients told us they did not always get updates from their complaints.

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

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Senior managers did not always have a good understanding of the services they managed. Senior managers were not always visible in the service or approachable for patients and staff. However, ward leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Not all staff and patients knew who the senior managers were. Senior managers are managers above ward manager level. We were told senior managers rarely go onto the wards unless Care Quality Commission staff are inspecting them. Five staff told us senior managers do not listen to them when they tell them the wards are short staffed and when this is reported to senior managers they get questioned as to the accuracy of this information. However, staff told us ward managers were very visible and they could approach them with any concerns.

Ward managers had the right skills and abilities to run a service. They understood the service they managed.

Vision and strategy

Staff knew and understood the provider's vision and values. However, staff did not always apply them in their teams.

Staff knew and understood the providers vision and values and the hospital's leadership team had communicated these to staff, but staff did not always apply them to their work.

Culture

Not all staff felt respected, supported and valued by senior managers. Not all staff felt they could raise any concerns without fear of retribution from senior managers. Senior managers are managers above ward manager level. The service did not always provide opportunities for development and career progression. However, staff felt respected, supported and valued by the ward managers. staff felt they could raise any concerns without fear of retribution from the ward managers.

Seven staff across both Oak and Church wards did not know what a closed culture was. Care Quality Commission inspectors explained the meaning of this to staff despite senior managers saying they worked with staff on this. Two staff told us that they felt there was a closed culture across the learning disability division once they understood it's meaning.

Not all staff felt respected, supported and valued by senior managers. However, staff told us they felt respected, supported and valued by ward managers.

Staff did not feel able to raise concerns without fear of retribution from senior managers.

Staff knew how to use the whistle-blowing process if they needed to.

We saw numerous certificates in the office on both wards that staff success was celebrated in line with the provider's vision and values and staff received certificates monthly. Patient success was also celebrated in weekly community meetings and we saw patients receive certificates for their weekly achievements.

Governance

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

Although senior managers ensured there were structures, processes and systems of accountability for the performance of the service, senior managers did not appear to support staff even when these systems showed consistently staffing was an issue across the wards. We viewed monthly governance minutes from April 2021 to June 2021 which stated there were staffing issues across all wards. The same concerns were discussed each month with no outcome or solution.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed at a ward and senior management team level meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

The providers data was not always accurate. For example, we requested the provider send us the data to reflect how many patients used long-term segregation between 01 April 2021 and 30 June 2021. The provider reported one use of long-term segregation on Oak ward. The provider reported no use of long-term segregation on Church ward or Sycamore ward. Despite this, at the time of our inspection we saw two patients in long term segregation on Church ward who had been in long-term segregation for several months. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

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

Senior managers did not effectively manage ward performance despite using systems to identify, understand, monitor, and reduce or eliminate risks. We saw evidence in governance meeting minutes of these risks being escalated but we saw no evidence of an outcome to these.

Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Information management

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

Staff had access to the equipment and information technology needed to do their work.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Wards were not always safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not always complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified.

The Ashby ward environmental risk assessment was last updated in December 2020 and had not been updated to reflect restrictions currently in place around locking the toilet and garden doors. The assessment did not mention concerns around the stairwell next to the lift which was open and required blocking in for the safety of the patient acuity mix on the ward. However, staff routinely updated Naseby and Upper Harlestone environmental risk assessments.

Staff could observe patients in all parts of the wards.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were not always clean, well maintained, well-furnished and fit for purpose. Patients and carers told us there has frequently been issues with toilets blocking, shower heads spraying and light bulbs in bedrooms needing replacing. One patient told us that there had been a shower blocked in their room for up to three months, which constantly flooded the bedroom, but no one could come out to repair it due to COVID-19.

Staff made sure cleaning records were up to date.

Staff followed infection control policy, including handwashing.

Seclusion room

The seclusion room was on Naseby ward, with direct access from Ashby ward and was shared across the service, it allowed clear observation and two-way communication. It had a toilet in the connected extra care suite and there was a clock.

Clinic room and equipment

Clinic rooms were not fully equipped with accessible resuscitation equipment and emergency drugs. The resuscitation equipment and emergency drugs from Ashby was shared between wards and we were concerned staff would not always have easy access.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We reviewed staffing levels across Ashby ward for the previous 28 days prior to our site visit on 6 July 2021., During the day shifts only six out of the 28 days were staffed at optimum levels. We interviewed 13 multi-disciplinary team staff and they told us they were allocated to frontline shift work due to staff shortages as often as one full day a week.

We spoke with 33 staff of all grades and levels beneath management across Ashby, Naseby and Upper Harlestone wards who told us that staffing levels are constantly short. Staff described working over their hours to complete work, not having time to eat lunch and staying after their shift ended as there were no qualified staff on the next shift. Three nurses from Ashby and Upper Harlestone wards told us it is difficult to plan the day as there is not always enough restraint trained staff on shift. Staff on Upper Harlestone told us that there is always less staff on the ward at the end of the day due to staff being moved to support other wards. We observed at one point on Upper Harlestone ward that there was only one qualified staff on shift with no team leader or ward manager. Staff advised there should be three qualified staff on shift.

Patients on Ashby ward told us “they did not feel safe due to staffing levels, staff did not get a break and they are pushed to the limit”. Patients told us that there is not enough staff to manage incidents as they occur. They told us that staff are often injured. One patient told us there was a lack of staff to monitor the ward which meant she was afforded the opportunity to cause herself harm. We observed two staff members being injured on Ashby ward, one needed to go to accident and emergency.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The vacancy rate for staff varied across wards. The provider reported a qualified vacancy rate of 16% as of July 2021. Thornton reported the highest rate at 15% and Naseby the lowest at 0%. The provider reported a vacancy rate of 11% for unqualified staff. Thornton reported the highest at 35% and Upper Harlestone reported the lowest vacancy rate with a fill rate of 104%.

The service reduced its use of agency staff. The provider reported agency staff were used to cover 1% of all shifts between 1 April 2021-30 June 2021.

The service increased its use of bank staff. The provider reported bank staff were used to cover 19% of all shifts between 1 April 2021-30 June 2021.

Managers told us they tried to request staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates. The provider reported a turnover rate of below 1% between 1 April 2021-30 June 2021. When staff moved it was often to a different area within the provider. Staff told us they have been forced to move wards.

Levels of sickness were average. The provider reported a sickness rate of 8% of between 1 April 2021-30 June 2021. This was highest on Upper Harlestone and Ashby ward with 9% and lowest on Thornton ward with 5%.

Managers did not always support staff who needed time off for ill health. Staff told us that on returning to work after an incident on the previous shift they were not asked how there were and no return to work interview was done, other staff told us they had not been supported after returning from long term sick, one staff member had to cancel appointments with occupational health on two occasions due to staff shortages on the ward.

Managers could not accurately demonstrate how many staff were on shift. Nurses and healthcare assistants could be moved to a different ward throughout a shift, and they were reliant on the bank team managers updating the system in a timely manner to reflect this.

The ward manager could adjust staffing levels according to the needs of the patients, but they were not always able to access the additional staff they required.

Patients had regular one-to-one sessions with their named nurse.

Patients and staff told us on escorted leave and activities were cancelled due to the service being short staffed. We spoke with eight patients and 15 carers and five told us that activities and leave were cancelled. On Ashby ward two patients and two staff told us there was no activity at weekends.

The service did not always have enough staff on each shift to carry out physical interventions safely. Qualified nurses told us when they look at planning the day, they did not always have enough restraint trained staff on shift. Three nurses from Ashby and Upper Harlestone wards told us although they try not to put staff on back to back observations this sometimes happens due to staff shortages.

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.

Mandatory training

Not all staff completed and kept up to date with their mandatory training. The provider reported a mandatory training rate of 96% for the Women's long stay rehabilitation service as of 5 July 2021. The provider reported compliance of 75% or below for the following courses and wards- Safeguarding level 3: Ashby- 70% and Thornton- 71%. Immediate life support/identifying a deteriorating patient- Thornton- 71%. Effective record keeping: Ashby- 64% and Thornton- 75%.

Bank and agency staff were not always restraint trained. Two staff told us they did not always have time on shift to complete their mandatory training.

However, the mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion prior to de-escalation.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. Risk assessments available to review on inspection had not been updated after each incident. Healthcare assistants did not consider risk assessments to have anything to do with them. However, following the inspection the provider supplied risk summaries for seven patients.

Management of patient risk

Staff did not always know about risks to each patient, staff did not always act to prevent or reduce risks. We reviewed 12 records and risk assessments were updated routinely but were not updated after each incident. Staff could not find the most up to date information when they needed it. Staff could not identify and respond to changes in risks to, or posed by, patients. We reviewed an incident where it stated on handover that a patient should be put in secure clothing overnight, staff did not do this and as a result there was a serious incident.

Ashby ward reported 142 incidents of patients self-harming whilst on enhanced observations from 1 April 2021 to 30 June 2021. Of the 142 incidents, 115 incidents occurred when patients were on arm's length observations. Upper Harlestone ward reported 135 incidents of patients self-harming whilst on enhanced observations from 1 April 2021 to 30 June 2021. Of the 135 incidents, 106 incidents occurred when patients were on arm's length observations. An incident occurred during the inspection whereby staff did not observe a patient as prescribed resulting in the patient self harming and requiring emergency medical treatment.

Staff followed the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Use of restrictive interventions

Levels of restrictive interventions were high on all wards and staff applied blanket restrictions around vaping times, laundry rotas and toilets access. On Ashby and Upper Harlestone ward there was not free access to the courtyard. On Ashby ward patients were not able to freely access hot and cold drinks. The provider supplied evidence from 1 July 2021 that showed restrictive interventions were reviewed in daily huddles.

The provider reported 1,016 restraints between 1 April 2021-30 June 2021. Naseby reported the most with 496. Thornton reported the fewest with one. Of the 1,016 restraints 25 were prone restraints, 11 of these were on Naseby ward.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff had not made every attempt to avoid using restraint by using de-escalation techniques. Patients and carers told us that staff did not always use de-escalation prior to use of restraint, one carer told us the staff "are hands on and did not try and de-escalate and they did not explore least restrictive option, prior to going straight to restraint".

Staff did not always follow National Institute of Clinical Excellence guidance when using rapid tranquillisation. The provider reported 239 uses of rapid tranquillisation between 1 April 2021-30 June 2021; 91 on Naseby, 90 on Ashby and 58 on Upper Harlestone. Staff did not always monitor patients' physical health following the administration of rapid tranquillisation.

The use of seclusion was reducing. The provider reported 25 seclusion incidents between 1 April 2021-30 June 2021. Ashby ward reported the most with 22 and Naseby reported three.

Staff did not always keep clear records or follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in seclusion. We reviewed records for two episodes of seclusion for a patient on Ashby ward who was secluded in Naseby ward's seclusion room. We found the paperwork met some, but not all the guidance in the Mental Health Act Code of Practice. Staff had not documented what the patient had taken into the seclusion room. We were unable to find evidence of an independent multidisciplinary team review taking place after the patient's eight hours of consecutive seclusion. In the care plan relating to one episode of seclusion, there was no plan as to how the patient's needs were to be met, how de-escalation attempts would continue and how risks would be managed. Staff recorded "encourage patient to come up with a plan".

The provider reported one incident of long-term segregation between 1 April 2021-30 June 2021, this was on Ashby ward.

Staff did not always keep clear records or follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. We reviewed the long-term segregation paperwork of an Ashby ward patient who was in long-term segregation on Naseby ward. We found the paperwork met some, but not all of the guidance in the Code of Practice. For example, over a period of seven weeks, there was no evidence of the patient's situation being formally reviewed by an approved clinician in any 24-hour period on five days. In the same period, we were unable to find evidence of two reviews taking place on a weekly basis by the full multidisciplinary team. There was no evidence of a periodic review by a senior professional who was not involved in the patient's case.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff completed training on how to recognise and report abuse.

The provider reported the following rates for level three safeguarding training; Ashby ward 70%, Naseby ward 87% and Upper Harlestone 78%. However, staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Safeguarding referrals were made by the social workers on each ward, staff knew who to inform if they had concerns. Staff told us on occasions safeguarding reports can be late due to social workers and social worker assistance being brought into ward staffing numbers to support the ward.

Managers did not take part in serious case reviews and make changes based on the outcomes. We found no evidence of this.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were available, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff always regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines. Staff told us as there is only one nurse after 17.00, they are required to call a qualified nurse from another ward if drugs needs dispensing. Medics told us on occasions they have been called to support with dispensing drugs due to nurse shortages.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were not in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Ashby ward reported high use of rapid tranquillisation, on average, 25 incidents a month. Staff did not review the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance. We reviewed care records of three patients on Ashby ward following the administration of rapid tranquillisation. Staff had not recorded physical observations following the use of rapid tranquillisation.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Track record on safety

The provider reported 1,343 incidents for this service between 1 April 2021-30 June 2021. Naseby reported the most with 570, Thornton reported the least with 31. The most common incident type was 'Self harm' accounting for 632 reported incidents.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.

Staff told us they knew what incidents to report and how to report them. Staff told us they have access to the provider's reporting system, and they know how to report incidents. However, staff did not always report serious incidents in line with provider policy. We reviewed the incident report for an incident witnessed by the inspection team and staff had not accurately reported the incident.

We observed local and divisional huddles where incidents were discussed and reviewed incident reports. We found discrepancies in how they were reported. Staff told us that serious incidents are downplayed by managers. Staff told us incidents are not always reported straight away, and that incidents are not being documented thoroughly.

Managers did not always debrief and support staff after any serious incident, Staff told us that they did not always receive feedback from incidents. Staff had not always been supported by managers. Staff told us that debriefing after incidents was not happening currently due to staffing shortages. Staff told us they did not always receive feedback from investigation of incidents.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff did not always assess the physical health of all patients on admission. However, they assessed the mental health of patients and developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed mental health needs but care plans were not always personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Staff did not complete physical health assessments on all patients on admission or soon after. Staff reviewed most patients' physical health during their time on the ward. We reviewed 14 sets of care records; staff had updated patient's physical health records in 13 records. Staff had not updated one record for over two months.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. However, staff did not regularly review and update care plans when patients' needs changed. Staff had not updated one patient's care plan for over three months. Staff had not updated a care plan for nutrition for three months for a patient requiring nasogastric feeds. Out of the 14 care plans reviewed, seven were not always personalised, holistic and recovery orientated.

Best practice in treatment and care

The provider described the service as specialist rehabilitation, however staff did not always provide a range of treatment and care for patients based on national guidance and best practice for a rehabilitation service. This did not always include support for self-care and the development of everyday living skills and meaningful occupation. Staff did not always support patients with their physical health and living healthier lives. However, staff provided psychological therapies and used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Ashby, Naseby and Upper Harlestone wards provided a dialectical behavioural therapy service for patients with a diagnosed emotionally unstable personality disorder. Thornton ward offered slow stream rehabilitation for women.

Staff did not always provide a range of care and treatment suitable for the patients in the service.

Staff did not always deliver care in line with best practice and national guidance (from relevant bodies e.g. National Institute for Health and Care Excellence).

Staff did not always identify patients' physical health needs and recorded them in their care plans. Staff did not always make sure patients had access to physical health care, including specialists as required. We reviewed care records for 14 patients. On Upper Harlestone staff did not complete physical observations as required. Staff on Ashby ward did not record neurological observations for patients following episodes of head banging on 46 occasions in June 2021. We reviewed care records of three patients on Ashby ward following the administration of rapid tranquillisation. Staff had not recorded physical observations post administration. Patients could be exposed to the risk of harm if they did not receive the necessary monitoring.

Staff did not always meet patients' dietary needs and assess those needing specialist care for nutrition and hydration. We reviewed care records on Naseby ward where a patient on a nasogastric tube and another patient who had shown deterioration in her blood results had not seen a dietician for over two months. On Upper Harlestone staff missed one nasogastric tube feed for a patient over the last two months.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. However, On Upper Harlestone, since moving in July 2020, staff have not provided suitable storage in patients' bedrooms for self-medicating patients and they are still required to request their medication via the clinic room.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Teams used Health of the Nation Outcome scales, physical health assessments and recognised occupational therapy assessment tools. On Upper Harlestone ward staff used 'Management of Really Sick Patients with Anorexia Nervosa' (MARZIPAN) to monitor and assess patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives, the dietician from Upper Harlestone ward was part of the East Midlands eating disorder network, and routinely attended external training and shared the information with the team.

Skilled staff to deliver care

The ward teams included or had access to the full range of 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. However, managers did not always support 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 a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

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

Managers did not always support staff through regular, constructive appraisals of their work. Staff told us that there is no routine feedback mechanism between ward managers and bank staff managers, so unless they identify an issue with the bank staff member it is not fed back. Managers did not always support non-medical staff through regular, constructive clinical supervision of their work. Bank staff told us that they did not have routine supervision or appraisals, after their initial three months review.

We requested supervision data, which was not initially provided. However, we subsequently received data which reported a compliance rate in May 2021 of 98% for management supervision and 75% for clinical supervision.

Managers did not make sure staff attended regular team meetings. Staff told us due to being short staffed meetings did not always take place, and they were not always free to attend. Managers gave information to those who could not attend. Managers told us they gave staff the option of attending team meetings virtually.

Managers identified any training needs for permanent staff, however, staff told us they do not always have the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance in permanent staff and could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not always work together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients. However, staff did not always make sure they shared clear information about patients and any changes in their care, including during handover meetings.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

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 and discharged these well. 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. Permanent staff across all wards had a compliance rate of 93% for Mental Health Act training.

Patients did not always have easy access to information about independent mental health advocacy. Staff told us that St Andrews Healthcare had a recent change of advocacy providers and staff on Ashby ward were unclear how to access the new service, staff told us there had been lack of advocacy support over the COVID period.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

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.

Staff did not always make sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients, carers and staff told us that section 17 leave was cancelled due to staff shortages.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Permanent staff across all wards had a compliance rate of 93% for Mental Capacity Act and Deprivation of Liberty training.

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.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness. They did not respect patients' privacy and dignity. They did not understand the individual needs of patients and support patients to understand and manage their care, treatment or condition.

Staff were not always compassionate and kind when caring for patients. We observed on Ashby ward a patient in distress due to noise coming from another patient in the extra care suite. Staff turned up the music channel, but no one attempted to support the distressed patient.

We observed a patient in distress whilst in seclusion on Ashby ward, the patient was banging their head on the wall. The staff member observing the patient made no attempt to intervene or support the patient with their distress. We noted this continued when we re-visited the seclusion area later in the day. We raised this to the provider as an immediate concern.

We reviewed seclusion records for a patient on Ashby ward and staff documented on one occasion that, "… continues head banging hard on the seclusion door", however, there was no evidence as to how staff intervened in this situation.

A patient on Ashby ward stated, "staff can be dictators, and treat us like children, other staff cannot cope, and they are a nightmare". She stated what she says to the staff falls on "deaf ears". Another patient from Ashby ward told us that some night staff tried to de-escalate situations, but most immediately turned to rapid tranquillisation. One carer told us the system felt punitive rather than encouraging and rewarding. One carer told us her daughter had been refused her visit after an incident. This upset her as she was not aware her mum would be visiting.

Staff did not always respect patients' privacy and dignity. Patients and carers from Ashby ward told us the toilets were often blocked, one patient told us she asked three times to go to the toilet but was told she would have to wait until she could go up to her room. Another carer told us a patient waited 45 minutes to gain access to a toilet after she requested to go. Patients told us they felt they were a burden when they requested to go to the toilet. Another patient told us she frequently waited up to 15 minutes to gain access to a toilet after she has requested to go.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff on Naseby and Upper Harlestone wards supported patients to understand and manage their own care treatment or condition. Patients told us there are some “good” and “fantastic staff”, but they get “pushed to the limit.”

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment, staff did not always actively seek patient feedback on the quality of care provided. They did not always ensure 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.

Staff made sure patients understood their care and treatment.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were chaired by patients and patients set the agenda. We reviewed community meeting notes where patients raised concerns and they had been appropriately actioned. However, in six meetings between May and June 2021 patients reported the same maintenance concerns and food issues. Although staff escalated these issues there were delays in addressing them.

Managers did not always make sure patients could access advocacy services. The provider recently changed their advocacy provider and staff on Ashby ward were unclear how to access the new service, staff told us there had been lack of advocacy support over the COVID period either in person or virtually.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff support, information and involvement for families or carers was inconsistent. Carers told us that contact from staff was erratic, sometimes they would receive several calls a week and then not have contact for extended periods of time. Staff told us families are not involved in patient care.

Staff did not help families to give feedback on the service.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Data provided for Ashby ward showed bed occupancy at 89%. Upper Harlestone was 69% and Naseby was 63%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay for Ashby ward was 832 days, Naseby ward 860 days and Upper Harlestone 437 days.

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.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had a low number of delayed discharges in the past year. There was one delayed discharge for Ashby ward.

Managers monitored the number of delayed discharges.

The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. 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, patients could not always make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private, although the public phones in each ward were not available at the time of our visit due to phone leads being a risk to patients.

The service had an outside space, on Ashby and Upper Harlestone ward this was locked, on Naseby ward there was open access.

Patients could access hot drinks on Naseby and Upper Harlestone but had to request access on Ashby ward. Fruit was available on Ashby for patients without staff access, however, on Upper Harlestone snacks were monitored and there were specific times they could access them.

The service offered a variety of good quality food. However, we reviewed community meeting notes which highlighted requests for pure juice at breakfast which was raised at several meetings prior to it being actioned.

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 although during the COVID period this diminished.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and wider community.

Meeting the needs of all people who use the service

The service did not meet 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 not always support and make adjustments for disabled people.

The service inclusion criteria states, "The unit is able to meet the needs of women with moderate or transient physical disability and concurrent physical health problems (e.g. epilepsy, diabetes). Certain physical limitations may preclude the acceptance of a patient unable to use stairs". The service accepted patients to Ashby and Upper Harlestone ward who used a wheelchair. Staff had not made reasonable adjustments to ensure the patients could evacuate in an emergency. We reviewed one patient's emergency evacuation plan which stated that an emergency rescue and evacuation aid mat would be used to bring her down the stairs. At the time of our inspection the service did not have the required evacuation aid mat. They did however have an evacuchair available which was locked in a cupboard at the top of the stairs. Staff stored the keys downstairs in an office at the other end of the ward. Staff had not received Evacuchair training and were unaware of the key location. Managers could not assure us that staff trained to use the evacuchair worked on every shift. Staff on Upper Harlestone ward described the evacuation plan for wheelchair users was to take the patient through the upstairs corridors to Ashby ward. This required passing through many locked doors. We were not assured that in the event of an emergency staff would have the right knowledge and equipment to support patients to safety.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Listening to and learning from concerns and complaints

The service did not always treat concerns and complaints seriously, investigate them and learn 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.

The service clearly displayed information about how to raise a concern in patient areas.

We have requested information from the provider around compliments and complaints, but we have not received this.

Managers did not always share feedback from complaints so staff could learn and to improve the service. Staff told us they have not received feedback from complaints.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not always have the knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed. However, they were visible in the service and approachable for patients and staff.

We interviewed ward managers, their experience in their roles varied based on their length of time in the roles. Some were unable to answer all of our questions due to inexperience. Managers who had been in post longer had an understanding of their role and the service they managed. Clinical nurse leaders had not always had the right training to access management reports, in the absence of their ward manager.

Vision and strategy

Staff knew and understood the provider's vision and values but did not always apply them to the work of their team.

Staff knew the providers four care values, Compassion, Accountability, Respect, Excellence but did not always apply them to their work and within the team. Staff were not always respectful, kind and compassionate when caring for patients.

Managers did not always show respect compassion or accountability or excellence with staff. Managers did not always support staff who needed time off for ill health.

Culture

Staff did not always feel respected, supported and valued. 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 told us they did not feel respected or valued, three staff told us that they were made to move wards with no explanation, and when they requested further information, from local management and by formally writing to Human Resources, they did not get a response.

Staff gave a variety of other feedback including: they come to work when physically unwell, they cannot sleep due to work anxiety and they feel panicky coming to work. Staff told us they feel stressed, not supported and feel guilty leaving their shift.

Staff told us they felt burnt out. They told us staff shortages was having a negative effect on their mental health and two staff told us that there is a high level of staff burnout. One staff member told us they sometimes work a 13-hour shift without a break or time to get their lunch out of the fridge. Staff told us they frequently work beyond the end of their shift feeling they cannot leave, and one member of staff told us they came in on their day off to catch up with their work.

A patient told us staff did not get a break and they are pushed to the limit, and they have seen staff break down in front of them.

Managers we spoke to had been part of the provider's nurse training programme and had been given opportunities to develop their career within the organisation.

Governance

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

The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed breaches identified at previous inspections or staff failures to follow the provider's procedures on risk management and incident management and reporting. We observed that staff did not record incidents accurately. Staff told us that due to staffing levels they often reported incidents after the shift when they had time, so it was not live information.

Managers did not routinely feedback incident investigation outcomes to staff and reflection sessions were not always held to learn from these at a local level. Staff told us reflective learning sessions were often cancelled due to short staffing, and that if they do go ahead, staff often are unable to attend.

Staff told us that work around safeguarding referrals can be delayed due to multidisciplinary staff being pulled into the ward staff numbers.

The providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and could not always use that information to good effect.

Staff did not always have access to information, they did not have the opportunity to read essential patient information or emergency evacuation plans. Multiple folders containing information meant staff did not have the capacity, due to staffing levels, to read all required information. Managers and staff on Ashby ward had not reviewed emergency evacuation plans so were unaware of the emergency escalation plan for the patient who mobilised using a wheelchair.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patient risk assessments available to view on inspection were not continuously updated after each incident. We were concerned vital information about patient risk was not up to date and accurate.

Information management

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

Management had a comprehensive audit programme.

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 On the psychiatric intensive care unit staff were regularly completing patient enhanced observations for longer than five hours at a time. Staff did not review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Two patients who were prescribed high dosage anti-psychotics did not have a care plan in place to monitor the effects on their physical health. When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. On the forensic wards staff did not always follow infection control procedures. Four staff on Willow ward were observed to be wearing masks incorrectly. This was reported to managers as we were concerned that Personal Protective Equipment was not being used effectively. The long stay rehabilitation wards were not always safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff did not always complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified. Patients and carers told us there has frequently been issues with toilets blocking, shower heads spraying and light bulbs in bedrooms needing replacing. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. On the wards for people with learning disabilities or autism seclusion rooms did not meet all the guidance in the Mental Health Act Code of Practice.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Across all core services the providers data was not always accurate. Executive leaders told us they were not able to capture accurate staffing data. The leadership, governance and culture did not always support the delivery of high quality, person centred-care. Leaders at the long stay rehabilitation services did not have the skills, knowledge and experience to perform their roles. Concerns identified at previous inspections had not always been addressed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing On the psychiatric intensive care unit the service did not have enough nursing and support staff to keep patients safe.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care On the wards for people with learning disabilities or autism staff did not always provide a range of care and treatment suitable for the patients in the service. The service had not fully responded to the needs of patients with autism in the ward environment. The design, layout, and furnishings of the ward did not always support patients' treatment.

This section is primarily information for the provider

Enforcement actions

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 Across the forensic wards staff missed opportunities to prevent or minimise harm. On Willow ward we found recorded evidence of incidents where patient observations had been missed and night staff had to remain on shift due to a lack of day staff. We reviewed an incident on Bracken ward whereby a patient was able to tie a ligature due to the day area being left unobserved. Staff did not always meet patients' dietary needs, and correctly assess patients who had specialist care needs for nutrition and hydration. We reviewed an incident on Willow ward that occurred in May 2021 where staff did not respond effectively when a patient refused diet and then fluids. This resulted in the patient being admitted to the acute hospital for rehydration. The acute hospital raised this concern as a safeguarding for investigation. On Bracken ward patients could not make hot drinks and snacks independently of staff. All drinks were kept in the office and patients had to ask staff to make them. If the ward was short staffed this could result in a delay to patients receiving a drink. On the long term rehabilitation wards staff did not always manage risks to patients and themselves well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour and levels of restrictive interventions were high. Staff did not always know about risks to each patient, staff did not always act to prevent or reduce risks. Staff did not always follow the Mental Health Act code of practice in relation to seclusion, long term segregation and blanket restrictions. The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the

This section is primarily information for the provider

Enforcement actions

wider service. Staff did not always assess the physical health of all patients on admission or support patients with their physical health. Staff failed to carry out recommended physical health observations following episodes of patients' head banging and administration of rapid tranquillisation medicine. Staff had not made reasonable adjustments to ensure wheelchair bound patients could evacuate in an emergency.

On the wards for people with learning disabilities or autism staff did not always manage risks to patients and themselves well. Staff did not achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff did not always act to prevent or reduce risks despite knowing any risks for each patient. Staff were not completing observation records in line with patients prescribed observation times or in line with provider policy. Wards had blanket restrictions in place. Not all patients could make hot drinks and snacks at any time. When a patient was placed in seclusion or long term-segregation, staff did not always follow best practice guidelines in the Mental Health Act Code of Practice.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Across the forensic wards, long term rehabilitation wards and wards for people with learning disabilities or autism there were not enough nursing and support staff to keep patients safe. Patients regularly had their escorted leave, therapies or activities cancelled because of staff shortages. On the wards for people with learning disabilities or autism staff had not completed specialist training to meet the needs of patients.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment On the wards for people with learning disabilities or autism patients were not protected from closed cultures.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Across the forensic, long stay rehabilitation and wards for people with learning disabilities or autism we identified closed circuit television in seclusion bathrooms were routinely on, regardless of whether the patient presented a risk necessitating this. On the forensic wards staff did not always treat patients with compassion and kindness or respect patients' dignity. A patient on Bracken ward was unable to get to the toilet in time due to a delay in staff assistance. Maple ward shared a seclusion corridor with a male ward. On the long stay rehabilitation wards staff did not always treat patients with compassion and kindness. They did not respect patients' privacy and dignity. Staff did not intervene to support patients when harming themselves or in distress. Staff did not ensure patients access to the toilet at all times. On the wards for people with learning disabilities and autism staff did not always treat patients with compassion and kindness. A female patient was allocated a male only team to observe her whilst in long term segregation.