Good

Northamptonshire Healthcare NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

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

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

We rated forensic inpatient/secure wards as good because:

- Patients had a positive experience of care and told us they felt safe on the unit. Patients attended community meetings daily, raised issues, and gave feedback to staff both at the meeting and through 'I want great care'. The service ensured patients and their carers knew how to make a complaint and patients had access to advocacy services.
- Staff described the electronic system to report incidents, how learning was shared and knew their role in the reporting process.
- Staff undertook comprehensive assessments and reflected patients' needs and goals. They completed individualised risk assessments at or before admission and updated them regularly according to need.
- All staff were trained in and had a good understanding of the MHA and MCA.
- Staff told us they felt supported to carry out their role and had regular appraisals. Some staff had undertaken specialist training relevant to the patients' needs.
- The trust had built a new seclusion room away from the main patient area. This helped to promote patient dignity. Ligature risk assessments helped staff to manage risk along with the use of anti-ligature fittings.
- Staff treated patients and their families with care, compassion and respect. The multi-disciplinary team worked well together and focused on patient recovery.
- Patients gave feedback through "I want great care." Patients scored on a variety of headings by using a computer tablet, which generated an overall score out of five. This was done every three months and at the time of inspection, the score was 4.6 out of 5. This process also enabled patients to raise individual issues.

However:

- Data provided by the trust indicated that prior to the inspection there had been four vacancies for qualified nurses and five vacancies for healthcare assistants, and the manager told us the service found it difficult to recruit male nurses.
- Staff were not able to see all areas of the ward and outside area as there were blind spots and CCTV cameras were not switched on, although staff mitigated this risk by zonal observations.
- It was not clear that supervision meant dedicated individual time for staff to reflect and learn.
- Medical staff felt that the trust had made decisions without adequate consultation, particularly over the changes to bed numbers on Wheatfield and Meadowbank. Medical staff felt that medical management was under-resourced, with the associate medical director and clinical director very thinly stretched.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The wards had a ligature risk assessment and staff knew where the risks were and how to manage them. The ward was equipped with a number of anti-ligature fittings.
- The trust had built a new seclusion room in the de-escalation room away from the main patient area and this contained an en-suite toilet, two-way communication, close circuit television, anti-ligature fittings and a clock.
- The patient-led assessment of the care environment (PLACE) scores for Berrywood hospital were 99% for cleanliness, which was above the national average. Ward areas were clean and neat and records showed the ward was cleaned regularly.
- Staff completed risk assessments on or before admission and updated them regularly. Patients' goals and positive risk taking were considered where possible.
- Staff knew how to report incidents and learning was shared. Staff and patients involved in and witness to an incident were offered debriefs when appropriate.
- The ward was secure with systems in place to manage safety and staff were issued with safety alarms.
- There was a good staff skill mix on the ward including specialist workers.
- Overall, the unit had met trust targets in mandatory training and all staff had completed safeguarding training. A social worker made regular ward visits and they reported that the team worked well with the local authority to highlight safety issues.

However:

- Staff could not see one corridor and parts of the outside area from the nurses' station or nurses' office. CCTV cameras were not in use and mirrors did not cover all blind spots, although staff mitigated this risk by zonal observations.
- Staff vacancy rates had been high for nurses and support workers and sickness levels were higher than the trust average. Bank staff covered the majority of shifts due to vacancy rates and sickness.
- Although medicines were stored securely and all medicines were in date, a medication error had led to a patient receiving medication past the discontinued date. This had not been reported as a medication error to the local authority.

Summary of findings

- Two patients told us when they had returned from an off ward activity, they were able to gain access to the airlock through the initial door and there were no staff to admit them on to the ward.

Are services effective?

Good

We rated effective as good because:

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

However:

- Although staff received regular supervisory support at team meetings and reflective practice meetings, they did not meet the requirements for the trusts' definition of clinical supervision. Supervision rates between October 2015 and September 2016 did not meet the trusts target although there had been an improving trend over the past four months.
- Some staff felt service provision could be improved by accessing specialist training in personality disorder.

Are services caring?

Good

We rated caring as good because:

- Patients gave feedback at daily community meetings and could raise issues using 'I want great care'.
- Patients gave feedback through "I want great care." Patients scored on a variety of headings by using a computer tablet, which generated an overall score out of five. This was done every three months and at the time of inspection, the score was 4.6 out of 5. This process also enabled patients to raise individual issues.
- Staff we spoke with showed understanding of patients individual goals and needs.

Summary of findings

- Patients told us most staff were respectful, kind and caring.

However:

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

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff focused their attention on patients' recovery and worked with other professionals to find suitable placements for patients. Staff had considered ways to prevent delayed discharges and reduce bottlenecks.
- Patients actively participated in a daily community meeting where they could raise issues, concerns and complaints, which staff responded to quickly.
- Patients could access a number of activities both inside and outside the unit with support from staff. These included a jazz night, cooking, games, model making, gardening, take away and movie nights.
- Patients could use a cordless telephone to make private calls in one of the quiet rooms.
- Staff compliance with diversity and human rights training was 100%. The unit provided information about different faiths and it catered for people with religious food requirements when asked.

However:

- A lack of rehabilitation beds meant that some patients who were ready to be discharged spent longer on the unit than they needed because there was no room on the rehabilitation ward.

Are services well-led?

Good

We rated well-led as good because:

- The manager collected and used data about staff performance to assess how well the team was working and where they could make improvements.
- Staff told us morale was positive, they felt valued and managers were supportive**.**
- We saw evidence staff were open and honest when things went wrong.
- Staff knew and agreed with the trust's values and wanted to provide high quality, person-centred services and to make a difference.

Summary of findings

- Staff were able to submit items to the trust's risk register and knew how to whistle blow.
- Shift records showed there were sufficient staff on duty with a good mix of skills and experience.

However:

- Clinical supervision compliance was below the trust target. It was not clear how effectively staff were supported in their practice with only reflective practice meetings and team meetings.
- Sickness rates were at a level higher than the trust's average.

Summary of findings

Information about the service

The Wheatfield Unit is a low-secure facility for up to 16 male patients who have shown disturbed behaviour linked to a serious mental disorder, and who require intensive multidisciplinary treatment in a secure environment. The unit provides a service to people over the age of 18 who are detained under the Mental Health Act. It is adjacent to Meadowbank, a step down rehabilitation unit to which it refers patients when they are ready for further rehabilitation.

The Wheatfield Unit is part of Berrywood Hospital, Northampton. It is a purpose-built facility with many up-to-date amenities including a gym, sports area, library, multi-media room, arts studio, cafe and rooms for therapy sessions. The facilities are shared with Meadowbank rehabilitation unit. The trust states that it aims to help individuals on Wheatfield Unit re-build their lives in a safe and caring environment.

The service was last inspected as a joint service with Meadowbank in February 2015 and was rated overall as requires improvement. The caring and safe domains were rated as good. CQC identified the following areas of improvement:

- The trust must ensure that clinical audits are carried out regularly to monitor quality and the effectiveness of the service.
- The trust must ensure that staff receive training appropriate to their roles in MHA and MCA.
- The trust must start work on training all staff and develop systems to monitor and manage the effective use of the Mental Capacity Act and Deprivation of Liberty Safeguards. This is important to ensure that staff can use the legislation with confidence to protect people's human rights. Assessments of patients' capacity to consent under MHA are detailed enough and available for all patients.
- The trust must ensure that staff are monitoring patients soon after administering olanzapine depot injection and the units must have a protocol in place. This ensures that patients are observed for undesirable outcome.
- The trust must ensure that patients' privacy and dignity is protected at all times by locating the seclusion room away from the main patient area and have a telephone situated in an area that allows privacy.
- The trust must ensure that patient's individual needs are met and any necessary adjustments made to meet patient's individual needs.
- The trust must ensure that the governance processes in place to manage quality and safety monitors all areas of quality and safety within the units to ensure that improvements are made.
- The trust should monitor that there is consistent practice on Historical Clinical Risk Management (HCR-20) by ensuring that all patients have one and they are regularly reviewed.
- The trust should consider that the units' MDT have input from a pharmacist and social worker.
- The trust should consider training all staff on the use of the electronic records system EPEX.
- The trust should ensure that records of communication to explain to patients the results following the SOAD's visits are in place.
- The trust should consider reviewing blanket restrictions on plastic cutlery and crockery, set smoking times and hot drink times to adopt a more person centred approach.
- The trust should ensure that all patients have copies of their care plans.
- The trust should ensure that all staff are listened to and engaged with and review the work load of consultants.
- The trust should ensure that the forensic services are not isolated and disconnected to the rest of the trust.
- The trust should ensure that staff are not pressured to work extra shifts to cover staff shortages and review flexible working hours to all staff.

Summary of findings

- The trust should ensure that all information on performance is easily accessible to managers and staff on the units.
- The units are participating in a national quality improvement programme such as AIMS.

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

Our inspection team

Our inspection team was led by:

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

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

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

The inspection team consisted of a CQC inspector, and a variety of specialist advisors which included Mental Health Act reviewers and pharmacy inspectors. We were also supported by specialist advisors including two nurses and an expert by experience. An expert by experience is someone who has either used a service or has cared for someone using a service.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited the Wheatfield Unit at Berrywood Hospital and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients and two carers of patients who were using the service
- attended and observed a therapeutic group for patients
- attended a ward communication meeting for 14 patients and eight staff
- spoke with the ward manager and nine other staff members; including doctors, nurses, psychologists, occupational therapists, healthcare assistants, sports therapist and activities co-ordinator
- attended and observed one hand-over meeting and a staff training session

Summary of findings

- received feedback from patients at three focus groups
- looked at eight treatment records of patients
- carried out a specific check of the medication management on the wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Six of the eight patients we spoke with said they felt safe on the ward. Four patients said they felt safe because cameras were in place.
- Patients told us most staff treated them with kindness and respect. Three out of four patients told us staff may knock on their door but they would enter without waiting for an answer. We spoke with two patients who said one staff member was unfriendly.
- One patient reported he felt overwhelmed during a restraint due to the number of staff involved.
- Patients were positive about the food and some patients prepared some of their meals.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should review lines of sight throughout the ward to ensure effective observation of patients at all times.
- The trust should ensure that changes in medication are properly recorded in line with policy and protocol to minimise the chance of medication being administered after it has been discontinued.
- The trust should ensure staff receive formal clinical supervision.

Northamptonshire Healthcare NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

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

Mental Health Act responsibilities

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

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

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had completed Mental Capacity Act training. When we spoke with staff they demonstrated understanding of the principles of the Act and they told

us the training had been effective. Staff knew people should be assumed to have capacity and may need support with specific decisions. We saw examples of staff supporting patients to make decisions.

- The trust had a MCA policy, which staff were aware of and could refer to if needed. Staff knew where to find this and where to go for advice. There was a named trust contact and staff understood they could make contact or alternatively could talk to the unit manager or one of the multi-disciplinary team.
- All patients on the unit had been detained under the MHA and there had been no deprivation of liberty safeguards (DoLS) made in the last 12 months.
- We observed discussion between staff and patients concerning restrictive practices and the least restrictive option.

Good

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The unit was a single sex ward for male patients. All the rooms were single rooms so no one had to share their room with another patient.
- The nursing office was located at the centre of the ward and staff had clear sight of most of the corridors where bedrooms were situated. However, staff could not see all areas of the ward adequately and mirrors did not cover the blind spots. In particular, there was a corridor that staff could not observe from the nurses' station and there were no mirrors in place to help staff in the nurses' office to see what was happening. There were also some outside areas where staff could not observe patients from inside the ward. A member of staff maintained zonal observations to ensure that these blind spots were monitored at all times. There were CCTV cameras throughout the ward areas. The trust told us although CCTV was installed several years ago they have never been used due to objections raised by service user groups.
- The ward was equipped with a number of anti-ligature fittings. A ligature point is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. There were however, ligature points in communal areas including the communal bathrooms and in bedrooms. Staff managed and reduced risks by the use of individual risk assessments and observations. The wards had a ligature risk assessment and staff knew where the risks were and how they should manage them.
- The clinic room was clean, tidy and well equipped for carrying out physical examinations. Emergency medicines had documented daily checks and listed expiry dates. This included oxygen cylinders, which were full.
- A new seclusion room had been built with an en-suite toilet, two-way communication, a clock, close circuit television and anti-ligature fittings. There were a small number of blind spots but the service had placed mirrors to ensure that staff could observe patients at all times. The trust had built the new room in the de-escalation room in order to move it away from the main patient area. This had reduced the size of the quiet area where staff would try to calm distressed and disturbed patients.
- The ward areas were clean, tidy and well maintained and furnishings were adequate. Cleaning records and schedules showed that the ward was cleaned regularly. Staff completed environmental risk assessments and audits in relation to health and safety and infection control. The patient-led assessment of the care environment (PLACE) scores for Berrywood Hospital were 99% for cleanliness and 97% for condition appearance and maintenance. Both scores are above the national average.
- We saw that one of the empty bedrooms was in need of some minor repairs and redecoration.
- The ward was secure with systems in place to ensure keys were managed safely and effectively. The service issued safety alarms to staff to ensure the safety of patients and staff. Staff could summon help from other ward staff or from the wider hospital when needed.
- Two patients reported that they were able to gain access through the initial door into the airlock when returning from an activity off the ward and there were no staff available to admit them back onto the ward.

Safe staffing

- The trust had estimated the number of staff needed to provide safe staffing to the unit although the unit manager was not able to say how this was done. The manager reported that they could deploy additional staff when needed. The unit operated a shift system which ensured there were qualified nurses on duty at all times and sufficient staff to meet patients' needs safely. Staffing levels matched this on the majority of shifts we looked at and staff had taken steps to ensure that periods of sickness were covered. However, in April, May, July and September 2016, less than 90% of healthcare assistant shifts were covered.

Good

Are services safe?

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

- There was a good skill mix on each shift and specialist workers, including an employment co-ordinator and sports instructor, were additional to the shift numbers. The ward manager, psychologist and modern matron provided additional support and oversight.
- The trust reported that there were four vacancies for qualified nurses and five vacancies for healthcare assistants. Up to date figures indicated that at the time of inspection this had reduced to one nursing vacancy and two vacancies for support workers. Data provided by the trust showed that vacancy rates were 54% for nurses and 31% for healthcare assistants between September 2015 and October 2016. The manager reported that the service found it difficult to recruit male nurses and support workers and identified this as a significant issue. Sickness rates were higher than average for the trust at just over 6%.
- Bank staff, who were familiar with the ward and with patients, worked the majority of shifts uncovered as a result of sickness and vacancies. Agency workers covered a small number of shifts and the manager told us that he employed familiar staff where possible. Patients and staff told us there were few activities cancelled, including patients' 1:1 sessions and escorted leave, due to a lack of staff.
- A consultant psychiatrist and a speciality doctor provided medical cover to the unit. The consultant psychiatrist also worked with trainee doctors. They also provided out of hours cover to the unit, supplemented by the hospital response team, which included junior doctors and an on-call consultant. The manager and consultant told us that this enabled them to arrive at the unit in under an hour. The same doctors provided cover in relation to physical healthcare and referred patient to the emergency services or to hospital when appropriate.
- Staff had completed training relevant to their role. Overall, 90% of staff had completed mandatory training, which met the trust target. All staff had completed safeguarding training. However only 25% of staff had completed training in manual handling, 37% had completed immediate life support training and 63% were up to date with medicine management training.

Assessing and managing risk to patients and staff

- We looked at eight care records on the trust's electronic care record system. All patients had received risk assessments on or before admission. Staff completed Working with Risk (3) for all patients and used the historical clinical risk management tool, HCR-20 to assess levels of risk in relation to potential violence. Risk assessments were detailed, clear, used historical information to identify risks and staff updated them regularly. They contained information about the patient's goals and considered positive risk taking where possible. They focused on how staff could support the patient and the staff team to reduce and manage dangerous behaviours. Staff used HCR-20s in care programme approach (CPA) meetings and routinely updated them.
- Staff rarely restrained patients and reported incidents of restraint on the electronic recording system. There were 13 episodes of restraint between 1 October 2015 and 1 September 2016, all of which led to seclusion. Staff and the unit manager reported that they used de-escalation techniques to minimise the use of restraint, such as distraction, talking to the patient to see if the matter could be resolved and encouraging them into a different area of the ward. One patient confirmed that staff had tried to calm him, only restrained him as a last resort and carried out the restraint correctly. However, another patient reported that he felt intimidated due to the number of staff used in the restraint.
- There were 13 episodes of seclusion between 1 October 2015 and 1 September 2016. Staff had correctly completed seclusion paperwork over the previous six months.Seven of these were a prone restraint, which means that staff restrained patients in a face down position. One of these restraints led to rapid tranquilisation. Staff were trained in the prevention and management of violence and aggression (PMVA), although training rates for Teamwork, part of this training, were 77% which is less than the trust target.
- Rapid tranquilisation was rarely used on the unit. Two patients had been prescribed rapid tranquilisation medicines in line with trust policy and national institute for health and care excellence (NICE) guidelines.
- There were no informal patients on Wheatfield unit.

Good

Are services safe?

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

- Staff carried out observations on all patients every 15 to 30 minutes depending on the assessment of risk. This could be increased to 1:1 staffing when required.
- All staff had received training in safeguarding children and adults and were able to identify where abuse might be taking place. Staff, both qualified and unqualified, were aware of how to make a referral to the local authority and some staff were able to name the trust's safeguarding lead. Staff also reported incidents and concerns through the trust's electronic recording system. A social worker made regular, usually weekly, visits to the ward to liaise with staff and the unit manager. They reported that the team worked well with the local authority in relation to highlighting safeguarding issues. However, staff had not reported a medication error as a safeguarding to the local authority, after a patient had continued to receive medicine for six days after the consultant had discontinued the prescription.
- Medicines were securely stored on the unit. Medications were in date and staff checked the temperatures of both the clinic room and the fridge used to store medicines daily. These were within the correct range. All medicines were in date but nurses had opened four liquid medications without recording an opening date. Systems were in place for the ordering and disposing of medications. There was a pharmacy on site so medications could be located quickly. In addition, there was an emergency cupboard on site, which could be accessed when the pharmacy was not available.
- There were no missed doses or regular refusals. We found that the consultant psychiatrist had reviewed one patient's medication and discontinued it. It was correctly entered on the chart but the medication had not been crossed out from the date it had been discontinued. Nurses continued to administer the medication for six days until the the pharmacist discovered the error on their weekly checks. Charts showed that nurses dispensed medications and recorded them correctly apart from this instance.
- There were some blanket restrictions on the ward, for example in relation to mobile phones and internet access. These restrictions were justified and reasonable for a forensic environment.
- A room was available outside the ward for when children were brought on visits.

Track record on safety

- There were no serious incidents on the ward in the last 12 months. The manager shared information about one adverse incident on the unit. Staff had correctly reported this and improvements were made to the furniture in the dining area in response to the incident.
- The trust sent e-mails to staff in relation to learning from incidents that had happened across the trust. We also saw evidence that the team discussed serious incidents during team meetings.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on the trust's electronic recording system. They knew what incidents to report showed us how they would report them.
- Debriefs were offered after incidents. Where possible the patient was included in this discussion. The manager reported that consideration was also given to other patients who had witnessed an incident and found it distressing.
- Two staff told us that they discussed issues arising from incidents in supervision and during team meetings, handovers and reflective practice meetings facilitated by the clinical psychologist. Learning was shared, including improvements made as a result of the incident.
- The duty of candour requires providers to be open and transparent with patients when something has gone wrong. The trust had a duty of candour policy, which the service followed. We saw an example where staff apologised to a patient after he was given medication for a six-day period, which had not been prescribed.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

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

Best practice in treatment and care

- The consultant psychiatrist followed guidelines from the National Institute for Health and Care Excellence (NICE) when prescribing medication. There were no patients on olanzapine depot at the time of the inspection, but we saw evidence that staff monitored patients who were prescribed this medication in accordance with NICE guidelines. The consultant psychiatrist followed NICE guidelines when prescribing antipsychotic medication and this was seen in an examination of the prescription charts. The consultant psychiatrist also used other research to make clinical decisions about treatment. We discussed an example concerning the use of a drug to treat a patient with attention deficit hyperactivity disorder (ADHD) and to support him to give up smoking, using the latest research.
- The unit offered 1:1 psychology input for all patients and there was no waiting list for this treatment. A clinical psychologist, assistant psychologist and a trainee psychologist covered this unit and the adjoining rehabilitation unit. The psychologist also ran a number of groups, for example, on mindfulness and another on the treatment of substance abuse, which we observed.
- Staff focused on developing independence of patients through leisure activities and improving life skills.Staff spent time with patients to maximise their social and leisure interests such as a completing a variety of puzzles and games or playing pool; the occupational therapist and an activities co-ordinator helped plan and facilitate these activities. Staff supported patients to buy food and cook all their own snacks and meals in the facilities on the ward. They also worked with patients to gain work competencies and encouraged them to become more independent and self-motivated.
- The unit used the Health of the Nation Outcome Scales (HoNOS) and the brief psychiatric rating scale to assess patients' mental state and monitor their progress. HoNOS is the most widely used routine clinical outcome measure used by English mental health services.
- Clinical staff participated in clinical audits on the unit, such as weekly audits of the National Early Warning Scores and audits in relation to medication, seclusion, risk and ligatures. The junior doctor led this process but the manager was beginning to include nurses and other staff in this process. A pharmacist conducted weekly audits of medicine management.
- Access to physical healthcare was through the ward doctors who would refer onto other professionals as appropriate and doctors completed a full physical health checks were admission. Allergies were recorded appropriately and nutritional needs considered.

Skilled staff to deliver care

- The team consisted of a ward manager, nurses, a consultant psychiatrist, speciality doctor, psychologists, occupational therapist, activities co-ordinator and a sports therapist. The unit also had support from a pharmacist. The service had made links with local authority and a social worker visited regularly, although they were not part of the multi-disciplinary team.
- The staff team were a mixture of qualified nurses and unqualified healthcare assistants. Some staff had been newly recruited and others were extremely experienced. Staff received appropriate training at induction and

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

through regular updates. Records showed that mandatory training rates were high and that most staff were up to date with the majority of their training. The clinical psychologist also offered regular specialist training to the team to increase the effectiveness of the team and aid workers' personal development.

- Some staff expressed that there were gaps in services to meet patient's needs. In particular, one of the medical team felt that some patients would benefit from more specialist personality disorder provision.
- Staff reported that they had access to specialist training. The consultant psychiatrist and speciality doctors received addition study days and an annual budget to access specialist training. Staff gave us examples of additional training they had completed, such as courses in relation to sex offending, leadership and autistic spectrum disorders. Some staff had been supported to complete higher education programmes such as a master's degree and a doctorate.
- Staff received regular supervision every four to six weeks. Some staff said they received supervision more frequently than this. However, data provided by the trust indicated that between 1 October 2015 and 30 September 2016, only 74% of staff had received the trust target of ten supervision meetings in a 12 month period. In May and June 2016, supervision rates were 61%. Between September 2016 and the time of inspection, supervision rates were between 96% and 100%. The manager considered performance issues within supervision.
- Staff were also able to discuss clinical issues at the monthly team meeting and at reflective practice meetings and we saw this was taking place and was documented.
- Ninety three per cent of staff had received an appraisal in the last 12 months. Staff said they felt supported to undertake their role.

Multi-disciplinary and inter-agency team work

- There were daily multi-disciplinary handovers taking place when shifts changed. We attended one of these meetings and found that staff facilitated this well and that everyone attending contributed to discussions. Staff discussed physical health issues, using the national early warning scores to talk about patients' health status. They also discussed how the team could support patients to participate in activities away from the ward. The meeting concentrated on patients' problems rather than strengths, but staff attempted to identify positive and creative solutions.
- Different professionals within the multi-disciplinary team carried out assessments and they worked well together. Records also showed that the team worked in an effective way.
- Multi-disciplinary CPA meetings took place every six months and other meetings took place as necessary. There were good links with external professionals from health and social care agencies, including a multi-agency finance panel, which discussed discharge planning and with local authority social work team.

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

- Adults who are in hospital can only be detained against their will if they are sectioned under the MHA or if they have been deprived of their liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS). If patients are not subject to the MHA or the MCA DoLS, they can leave the unit, so need to know their rights. All of the patients on the Wheatfield unit were detained under the MHA. Five of the patients we spoke with said staff told them what their rights were under the Act. Records we looked at and staff we spoke with supported this.
- We looked at case records for eight patients. MHA paperwork was clear and correct in all cases. We looked at five medication charts all of which had the correct consent to treatment forms T2 and T3 in place and attached. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.
- All staff had received training on the MHA and code of practice. Staff we spoke with about the MHA said that the training demonstrated knowledge appropriate to

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

their position. Staff were aware of where to go if they required more detailed advice. Staff from the trust's MHA office also came to some of the unit's team meetings to do additional training.

- The consultant psychiatrist granted section 17 leave after assessment. Paperwork seen was clear and correct. We saw evidence of staff writing down what a patient was wearing prior to a period of escorted leave.
- Patients had access to independent mental health advocates. There were posters displaying this information and this was also contained in the welcome pack given when patients were admitted to the unit.

Good practice in applying the Mental Capacity Act

- All patients on the unit had been detained under the MHA and there had been no deprivation of liberty safeguards (DoLS) made in the last 12 months.
- One hundred per cent of staff had been trained in the Mental Capacity Act. Staff reported that this training was good and in discussion showed some understanding of the principles of the Act. They were aware that people are presumed to have capacity and may need support to make decisions for themselves. We saw examples of staff assisting and supporting patients to make decisions.
- The trust had a policy on the MCA and staff knew where to locate it. There were few mental capacity assessments made and staff said that the consultant psychiatrist would be responsible for undertaking them. Patients were assumed to have capacity and it was rare for staff to identify that a patient might lack capacity in a particular area. We were told this had happened in relation to one patient who had been assessed as lacking the capacity to look after his own finances, but we did not see evidence of this.
- We observed discussion between staff and patients concerning restrictive practices and the least restrictive option.
- Staff knew where to get advice regarding the MCA and could name the person they needed to contact in the trust. They also said they would speak to the unit manager or one of the other members of the multi-disciplinary team.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- The patient-led assessment of the care environment (PLACE) score for Berrywood Hospital as a whole was 90%, higher than the national average of 85%.
- We spoke with eight patients and observed how staff cared for patients on the unit. Patients told us that most staff treated them with kindness and respect.
- Two patients told us that while many of the staff were good, four staff members were unfriendly, unapproachable and unfriendly. This included staff commenting that opinions they expressed were indicators of their mental illness and a member of staff speaking to them rudely. Four other patients said that most of the staff were respectful but some were not. Three of the four patients said that some staff would knock on their door but enter without waiting for an answer. Patients also raised the issue of workers spending too long in the nursing office in the "I want great care" feedback.
- We saw examples of staff treating patients with kindness and understanding, individually and as part of group sessions.
- Staff talked to us about patients respectfully and showed understanding of their individual needs and goals.

The involvement of people in the care that they receive

- The unit had a welcome pack to give new patients information about the unit and services and options available to them, for example about the Patient Advice and Liaison Service (PaLS) advocacy. At the October 2016 team meeting, a member of staff had suggested doing a welcome pack specifically for carers, but at the time of inspection this had not been completed.
- Care plans had details of patient's views and demonstrated that patients had been involved in formulating their plans. Seven out of eight records we looked at stated that staff had offered them copies of the plan. Patients confirmed that they been given or offered copies and one patient said he had signed his copy. Some patients preferred to keep these in the nursing office and have access to them when required which the service facilitated. Patients were also involved in formulating risk assessments and the historical risk management tool HCR-20 which staff reviewed at care programme approach meetings.
- Patients had access to advocacy services. The unit promoted this through leaflets, the welcome pack and posters around the unit.
- The psychologist ran a carers' group, which was highly valued and well attended.
- Patients gave feedback through "I want great care." Patients scored on a variety of headings by using a computer tablet, which generated an overall score out of five. This was done every three months and at the time of inspection, the score was 4.6 out of 5. This process also enabled patients to raise individual issues.
- We observed one of the community meetings, which were held daily and were open to all patients. A wide range of staff attended these meetings, including consultants and the occupational therapist as well as staff based on the ward. All the patients attended and contributed to discussions about issues raised by patients such as frustrations with leave and restrictive practices. They also discussed how patients could be supported to present their views at a governance forum.
- One of the carers had raised at the group that no one had asked them for any feedback when they took their son out on leave and requested the opportunity to give feedback about the prayer room on the unit.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The average bed occupancy on the Wheatfield Unit between 1 October 2015 and 1 November 2016 was 93%. In both May and September this rate reached 100%. This exceeded the 85% recommended by the Royal College of Psychiatrists. There were no out of area placements for this service. The average length of stay for patients was 346 days between 1 October 2015 and 30 September 2016.
- The service had identified in November 2016 that patients blocking beds on Wheatfield continued to remain a problem. Staff referred to a bottleneck and described that those stable to be discharged have nowhere to be discharged to. Staff confirmed that the pathway from Wheatfield was compromised due to the lack of rehabilitation beds and community placements. This caused considerable frustration for patients. The trust had reduced rehabilitation services by closing the Brambles in 2015 and Quayside in 2016. This meant that patients requiring intensive rehabilitation were remaining at Wheatfield longer than was needed because of the lack of rehabilitation beds. The unit had four delayed discharges in a 12 month period from 1 October 2015, which was 40% of all discharges from the unit. The manager and consultant psychiatrist reported that while some patients had been discharged directly to community placements, most patients would need more intensive rehabilitation before discharge. Attempts had been made to reduce the problem by offering services from Meadowbank rehabilitation unit during the day to some Wheatfield patients. The trust had plans to reduce the number of beds on Wheatfield to 12 and increase the number of beds on Meadowbank from eight to 11.
- Staff remained focused on patients' recovery despite their frustrations at not being able to move people on when they were ready. The unit worked with other professionals to look at potential placements for patients. The manager attended a multi-agency finance panel for patients ready for discharge.
- There was no evidence of patients not being able to access a bed after returning from leave. The trust had not moved patients onto other wards for non-clinical reasons. All transfers were planned by the multi-disciplinary team with the involvement of the patient.

The facilities promote recovery, comfort, dignity and confidentiality

- The unit had a number of rooms for leisure and therapeutic activities. The clinic room was spacious had all the facilities and equipment needed to undertake physical examinations. The unit had quiet areas where therapeutic groups could meet or where patients could spend 1:1 time with their named nurse. There were programmes of activities, both on and off the ward, with weekly plans for each patient. There were also rooms where patients could meet visitors including a designated room off the ward, which staff used when children were visiting.
- The unit had removed the seclusion room from the main patient area and relocated it adjacent to the de-escalation room. This had a positive impact on the communal areas but some staff commented that it had a negative impact on the de-escalation facilities.
- Patients were allowed to use their mobile phones when on escorted leave but not on the unit. The unit had removed the telephone from the dining area because it did not enable patients to make calls privately and confidentially. The unit had a cordless telephone, which patients took to one of the quiet rooms to make private calls.
- The unit had a number of communal areas where patients could meet and take part in activities such as a variety of puzzles and games or pool. Staff supported patients to cook some of their own snacks and meals. Other activities, which were available throughout the week, included model making, gardening, movie nights and a jazz night in a local pub. The unit had secure garden areas which patients were able to access with some supervision. There was an occupational therapist and an activities co-ordinator who helped plan and facilitate these.
- Staff helped one patient to join a rugby club as this was one of his key interests. He has since played for them in their first team.

Are services responsive to people's needs?

Good

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

- The unit provided patients with a key to their room and they had access to their room at all times. Patients also had access to drinks and snacks, although access to the kitchen was supervised. One patient felt that there could be more variety as all the snacks were sweet.
- The patient-led assessment of the care environment (PLACE) score for food was 95%, which is above the national average of 90%. Some patients prepared some of their meals.

Meeting the needs of all people who use the service

- The unit provided information about services such as advocacy, including IMHAs, the MHA and treatments and there was also information provided about complaints. There were posters on notice boards and leaflets in English were available. Leaflets were not readily available in other languages and there were no notices in other languages about how to access information.
- Patients accessed an interpreter service, for those who spoke a language other than English.
- Staff compliance with diversity and human rights training was 100%. There were details of different faiths on the ward and one patient confirmed he was happy about how his religious needs were being met.
- There was a good choice of meals and the unit catered for people with religious requirements when requested. Patients made little comment about the food and what they did say was positive. The unit also has regular takeaway nights.

Listening to and learning from concerns and complaints

- There had been no complaints over the previous 12 months.
- Three patients said they were aware of how to make a complaint and would be able to do so if they felt they needed to. Information was made available in a variety of ways and patients were also able to speak to staff directly about their concerns. They could also raise issues in multi-disciplinary meetings, ward rounds and through the "I want great care" process.
- Staff facilitated a daily community meeting, open to all patients. Patients raised their concerns and we observed that everyone who attended contributed and raised questions where they were unhappy or unclear. We found that this was an extremely effective way of responding to patients' issues in a timely manner.
- Staff were aware of how to handle complaints appropriately and how to ensure they were reported. The manager told us that patients were encouraged to complain when they were unhappy about something and that most concerns raised were resolved informally. We saw this in community meetings and "I want great care". Informal concerns were not recorded as complaints.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

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

Good governance

- The manager collected data in relation to supervision, training and appraisals and used it to assess how the team was functioning and address areas of concern. Overall compliance with mandatory training was 90%, which was in line with the trust's target. The manager had a traffic light system in place to ensure this could be monitored effectively which alerted them to staff training needs.
- Supervision rates between 1 October 2015 and 30 September 2016 did not meet the trust's supervision target of 10 supervisions in a twelve month period. The trust provided data that 74% of staff met the trust's supervision target. The manager reported that supervision rates were now higher and further data provided by the trust showed that that this figure stood at 96% in January 2017. The unit manager reported that a system was in place to ensure that the manager supervised band six nurses who in turn supervised the healthcare assistants.
- It was not clear how staff received supervision. The manager reported that multi-disciplinary team meetings and handovers were part of supervision. Team meeting minutes stated that attending a staff meeting was classed as group supervision and that ward round, morning meetings and reflective practice were all part of supervision. We requested to see examples of staff supervision notes but these were not made available during the inspection. We spoke to staff who reported that they received monthly or six weekly supervision.
- We looked at shift records for the previous three months. There were sufficient staff on all shifts, qualified workers were always on duty and there was a good blend of skills and experience. The lack of male workers remained an issue, which the manager was attempting to address.We found examples of short staffing for short periods. We saw that staff rang round for cover whilst we were on inspection to ensure adequately staffing.
- Patients had identified that staff spent more time in the office than they would like and had requested through the "I want great care" process that they spent more time on the ward with patients. It was too soon to measure how managers had responded to this request.
- Clinical staff had started to do clinical audits and the unit manager was trying to include them in more of these tasks. The specialist doctor also undertook a number of audits.
- The unit arranged regular team meetings where they discussed incidents and complaints, including from other services in the trust. They held daily community meetings for service users to raise issues and staff gave feedback in a timely fashion.
- Staff made safeguarding referrals appropriately to the local authority and the manager had developed a good relationship with the local safeguarding team.
- Capacity assessments were carried out in relation to medication. Staff did not carry out Mental Capacity Act assessments routinely and we did not see any for patients currently detained on the unit. The manager said that there was no reason in the majority of cases to question that a patient lacked capacity. Staff spent time with patients, helping them to make decisions themselves.
- Staff submitted items to the teams risk register through the unit manager. The ward manager reported that they had enough authority to undertake their role and that they received appropriate administrative support.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Leadership, morale and staff engagement

- The unit manager was highly visible on the wards and offered high levels of clinical support and encouragement to staff.
- Sickness rates were around 6%, which was higher than the trust average.
- Staff knew the whistleblowing policy and were happy to raise concerns with the manager. Staff did not raise any instances of bullying or harassment with us during the inspection.
- The psychologist offered leadership and training to the staff group with assisted therapeutic work with patients and including Wheatfield patients groups run in a community setting. There was an imaginative and creative use of limited resources, which included working with another service in exchange for their psychologist doing some work with the staff group at Wheatfield.
- Morale within the team was positive and staff told us that their managers supported them to do a very stressful job. Close multi-disciplinary working also enabled staff to feel supported, and developed a common sense of purpose. The multi-disciplinary community meeting held every day and staff ensured this approach was focused on patient care. The trust had supported some staff to complete higher education qualifications.
- Staff were open and transparent when things went wrong and we saw an example of this.
- Medical staff felt that the trust had made decisions without adequate consultation, particularly over the changes to bed numbers on the Wheatfield unit. Medical staff felt that medical management was under-resourced, with the associate medical director and clinical director very thinly stretched.

Commitment to quality improvement and innovation

- The service had just joined the Quality Network for Forensic Mental Health Services. It had also recently started to use My Shared Pathway.
- The consultant psychiatrist was committed to using the latest research to treat patients. They were also a member of a development group for the mental health and justice system.